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ABSTRACT

The second volume in a 10-volume report on the historical development (1966-1973) of the 8 administrative Area Offices of the Indian Health Service (IHS) Mental Health Programs, this report presents information on the Aberdeen Area Office. Included in this document are: (1) Description of the Area (geography of the Area's Western Portion and tribal and cultural background of the woodland tribes and the Sioux reservations); (2) Development of Mental Health Services and Programs: Social Service Branch: 1955-65 (initial programs, Canton National Insane Asylum Aftermath, Flandreau Boarding School Project, and Deputy Social Service Chief for Mental Health); (3) Pine Ridge Community Mental Health Program (1965-66, Pine Ridge Mental Health Program overview, and research bulletin/publication highlights); (4) Expansion from Area Office to Other Service Units (1971-72, consultation model, 1969-73 suicide rates, service unit staffing patterns, North Dakota coordination, Social Service Branch and Mental Health Programs fusion, area-wide program/staff development, and the Bemidji Sub-Area); (5) Overview and Area-Wide Activities (Area Office functions, career ladder development, staff teaching activities, goals and format, and 1973 staff activities survey); (6) Service Unit Capsule Descriptions: 1973; (7) Summary (problems and achievements); (8) Appendices (1969-73 suicide statistics, Mental Health Worker Position Series Proposal, and treatment goals and intervention levels). (JC)

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Vol. 2, Set 1

ED133106

ABERDEEN AREA

Service Networks
and
Patterns of Utilization

Mental Health Programs I.H.S.

Partial fulfillment of
Contract No. 110-73-342

U.S. DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
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ABERDEEN AREA

MENTAL HEALTH PROGRAMS
OF THE
INDIAN HEALTH SERVICE

1965-1973

1975

IHS Contract No. IHS HSM 110-73-342

A documentary narrative in partial fulfillment of contract entitled:

Service Networks and Patterns of Utilization
Mental Health Programs
Indian Health Service

Prepared by

Carolyn L, Attneave, Ph.D. and Morton Beiser, M.D.

Department of Behavioral Sciences Harvard School of Public Health

This material has been prepared in connection with an initial evaluation contract to appraise IHS Mental Health Programs seven years after their formal introduction into the system in 1966. (IHS Contract No. HSM 110-73-342) As originally conceived the report was to be based upon a sampling of about three programs in the eight major Areas: One outstanding, one average, and one new or otherwise struggling. Administratively, Area Chiefs of Mental Health and their staffs found it impossible to participate in such a selection, and instead the staff has been required to inform themselves about over 90 programs and present their findings about each as objectively as possible.

The chapter for each Area follows a standard arrangement of information, varying in detail as the Area development indicates. There is first a description of the geographic and cultural context within which Area programs and Service Units work. Secondly, there is a reporting of the historical roots of mental health activities in the Area as far back in time as it has been possible to find evidence of them. In some instances this is coincidental with the formation of IHS in 1955, but in most it appears a few years before introduction of formal budgetted mental health staff. The latter sections of the report develop in chronological order (usually in two year segments) the personnel and activity of the Mental Health programs for the Area. Unique and special programs are presented in detail. Finally, an overview and summary of achievements and problems yet to be resolved concludes the description of the Area, which was completed as of the spring of 1973.

The concluding chapter of the report and the extensive sections on inpatient programs will be of interest to all Areas. It is also hoped that staff in one Area will find it of value to see what other Areas have done or are facing in the way of similar problems, and differing ones. However, when need arises, or interest is focused on only one Area, it is hoped that that chapter may be used as an independent unit.

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ABERDEEN AREA IHS

MENTAL HEALTH AND SOCIAL SERVICE PERSONNEL

1965 - 1974

AREA OFFICE: Aberdeen, South Dakota

Elizabeth Glasow-Chief Social Services Branch before Chief, Combined Mental Health and SS Branch	1972-
John Bjork, MS-Deputy Chief Social Services	1964-1971
Flandreau BIA School Project	1957-1963
Donald Burnap, M.D.-Chief Mental Health Services	1971-1972
Pine Ridge Mental Health Program Psychiatric Consultant	2/70-1/71
Robert Reisenberg, MSW-Deputy Chief MH and SS	1973-
Mental Health Coordinator N. Dakota	1971-1972
Social Worker, Belcourt N. Dakota	1970-1971
Angeline K. Walth, Secretary	

Belcourt, N. Dakota (Turtle Mountain) IHS Hospital

Robert Reisenberg, Social Worker (see Area Office)	1970-6/72
Betty L. Jeannotte, Social Work Assistant and Secretary	1971-1971
Mental Health Worker	1972-1972
Tom Laws, Social Worker	1972-
Lancelot Azure, Mental Health Worker	1972-
Psychology Technician	1973-
Janice M. Schlenvogt, Social Service Rep.	1972-
Joseph Wakefield, M.D., Psychiatrist	1973-1973
Diane Azure, Social Work Aide	1974-

Fort Berthold, Newton, North Dakota IHS Health Center

Melvin Walker, Social Worker	1971-1974
Darlene Finley, Mental Health Worker	1972-

Fort Totten, North Dakota (Devil's Lake) IHS Health Center

John F. Ulrich, Social Worker	1971-
Mary Angeline Alberts, Mental Health Worker	1972-1/74
John E. Dick, Social Worker	1974-

Fort Yates, North Dakota (Standing Rock) IHS Hospital

James Borland, Social Worker	1970-1971
James Rixner, Social Worker	3/71-
Delores D. Jochim, Mental Health Worker	1972-

Eagle Butte, South Dakota (Cheyenne River) IHS Hospital

Melvin Walker, Social Worker	1970-1971
Joyce J. Johnson, Social Work Aide	1971-
Mental Health Worker	1972
Psychological Technician	1973
Betty J. Claymore, Social Worker	1972-1974
Dorothy M. Clark, Mental Health Worker	1972-
Frank B. Harding, Ph.D.	1973-
Mary L. Arpan, Social Work Aide	1974-

Chamberlain, South Dakota (Crow Creek-Lower Brule) IHS Health Center

Joseph Davis, Social Work Representative	1972-
Mary Lou McGhee, Mental Health Worker	1974-

Rapid City, South Dakota IHS Hospital

Richard L. Varner, Social Worker	1970-1971
Thomas J. Walker, Social Worker	1970-1971
Cecelia Lee (Rohrbuck) Mental Health Worker	1966
Social Work Aide	1972
Social Work Representative	1972-

Mert Ecoffey, Secretary	1971-1972
A. William Haddow, Social Worker	1972-
Donald D. Annis, Social Work Assistant	1972-1973
Gene E. Dillon, Social Work Assistant	1974-
Sisseton, South Dakota	
Gary Lounsberry, Social Worker	-1970-1972
Louella May Quinn, Social Work Aide	1971-
Jolene Adams, Secretary	1971-
Tom Laws, Social Worker (see Ft. Belcourt)	1972-1972
Norman Lansdem, Social Worker	1972-
Rosebud, South Dakota IHS Hospital	
Cary N. Mack, Social Worker	-1970-1971
Eileen Lundermon, Social Work Aide and Secretary	1971-
Social Work Assistant	1974-
Paul T. Kirkham, Social Worker	1971-
Clement H. Soldier, Mental Health Worker	1972-
Charles T. Holguin, Mental Health Worker	1972-
Malcolm P. Rogers, M.D., Psychiatrist	1973-1974
Bernadine E. Waln, Clerk	1974-
Wagner, Douth Dakota (Yankton) IHS Hospital	
John J. Johnson, Social Worker	1974-
Niobra (Santee) IHS Health Center	
NONE	

Omaha-Winnebago, Nebraska IHS Hospital	
Stanley G. Remer, Social Worker	-1970-1971
Alphonse J. Folz, Social Worker	1970-1972
Rosalie M. St. Cyr, Social Work Aide	1971-
Mental Health Worker	1972-
Barbara M. Tyndall, Mental Health Worker	1972-1973
Patrick M. Tyndall, Mental Health Worker	1972-1972
Maxine T. Parker, Mental Health Aide	11/1973-
Patrick Hamilton, Social Worker	1973-
Bemidji, Montana Sub-Area Office	
Camille Riley Assistant Chief	-1970-
Harold Hinrichsen, Social Worker	1974-
Rhinelander, Wisconsin IHS Field Office	
David F. Folz, Social Worker	-1970-
David L. Besaw, Mental Health Worker	1972-
Psychology Technician	1973-
White Earth, Minnesota	
George W. Lefebvre, Social Worker	1972-
Cass Lake/Leech Lake, Minnesota Hospital	
Edward M. Byrnes, Social Worker	1971-1974
Red Lake, Minnesota	
Robert C. Pepper, Social Worker	1972-1973
Audrey J. Roy, Clerk	1972-

PINE RIDGE IHS
Part I - 65-70

Note this list, compiled from a variety of sources, is as complete as it was possible to retrieve.

1965

S. Eleanor Gill, Mental Health Consultant	1965-1968
Maurice Miller, Social Worker	1965-1968

1966

Carl Mindell, M.D., Psychiatrist and Director	1966-1968
Eileen Maynard, Ph.D., Anthropologist	1967-1970
Paul H. Stuart, Social Worker	1966-1969
Marvin Rossow, Social Worker	1968-1969
Acting Director	1968-
Pearl Black Elk, Secretary	1967-1969
James Mills, Social Worker	
Eileen Grinell	
Lucy Cuny (Copy Editor?)	
Levi Mesteth, Junior Research Assistant	
Sylvia Whipple?	
Lawson Waters?	
Gayla Twiss, Research Assistant	1968
Mental Health Worker	1968
Acting Director	1969-1975
Director	1975
Donald Burnap, M.D., Psychiatrist (few months 69)	
Donald Stendorf, Social Worker	
Sylvia Whipple, Statistician	
Stephen Silk, (Psychology Student, summers)	
Robert Church, Social Worker	1969?

1966 Continued

Delpha Waters, Head Secretary	1971-1974
Mental Health Worker	1974
Jo Anne Kilghea, Social Work Aide	-1968
?Myra Spindler, Social Worker	-1968

1970-1971

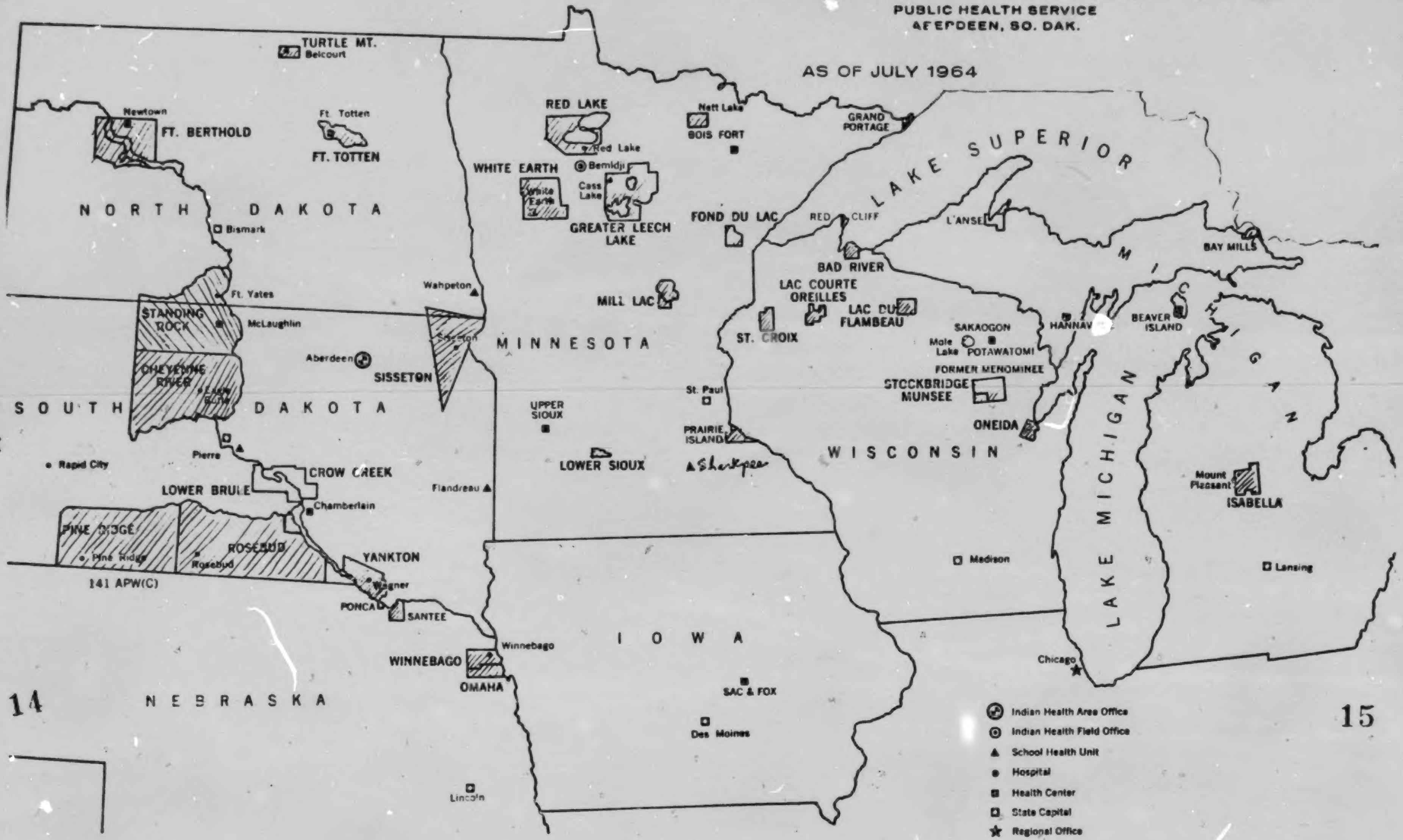
Stephen D. Fienstein, Chief Social Worker	1970-1971
Robert Church, Social Worker	?1970-1971
Donald G. Ostendorf, Social Worker (To Phoenix Area 1973)	1969-1972
John J. Cohn, Social Worker	?1970-1971
Cleo Hussman, Social Work Aide	?1971
Lambert McGuire, Social Worker	1971-1974
Francis Montileaux, Mental Health Worker	1972-1973
Psychological Technician	1973-
Frank S. Starr, Mental Health Worker	1972-
Arthur M. Brown, Mental Health Worker,	1972-1973
Psychological Technician	1973-
Robert P. Littledog, Mental Health Worker	1972-
Jeanne E. Rudy, Social Worker	1972-1974
Brenda A. Twiss, Mental Health Worker	1972-1973
Psychological Technician	1973-
Jay C. Mason, M.D., Psychiatrist	1972-1974
Cleo Marshall, Psychological Technician	1973
Mental Health Worker	1974-
Florence Romero, Secretary	1974-
Edward Byrnes, Social Worker (transfer from Bemidji)	1974-

INDIAN RESERVATIONS IN THE ABERDEEN INDIAN HEALTH AREA

U.S. DEPARTMENT OF HEALTH EDUCATION & WELFARE

PUBLIC HEALTH SERVICE
ABERDEEN, SO. DAK.

AS OF JULY 1964


TURTLE MT.
Belcourt
Newtown
FT. BERTHOLD
Ft. Totten
FT. TOTTEN
NORTH DAKOTA
Bismark
Ft. Yates
STANDING ROCK
McLaughlin
CHEYENNE RIVER
Eagle Butte
Aberdeen
SISSETON
Sisseton
Wahpeton
SOUTH DAKOTA
Pierre
Rapid City
CROW CREEK
LOWER BRULE
Chamberlain
Flandreau
PINE RIDGE
Pine Ridge
ROSEBUD
Rosebud
YANKTON
Wagner
141 APW(C)
PONCA
SANTEE
Winnebago
WINNEBAGO
OMAHA
NEBRASKA
Lincoln
RED LAKE
Red Lake
Bemidji
WHITE EARTH
White Earth
Cass Lake
GREATER LEECH LAKE
Nett Lake
BOIS FORT
GRAND PORTAGE
FOND DU LAC
MILL LAC
MINNESOTA
UPPER SIOUX
LOWER SIOUX
St. Paul
PRAIRIE ISLAND
Shakopee
IOWA
SAC & FOX
Des Moines
LAKE SUPERIOR
RED CLIFF
BAD RIVER
L'ANSE
BAY MILLS
LAC COURTE OREILLES
LAC DU FLAMBEAU
ST. CROIX
SAKAOGON
Mole Lake
POTAWATOMI
FORMER MENOMINEE
STOCKBRIDGE MUNSEE
ONEIDA
WISCONSIN
Madison
HANNAVILLE
BEAVER ISLAND
MICHIGAN
LAKE MICHIGAN
Mount Pleasant
ISABELLA
Lansing
Chicago
Indian Health Area Office
Indian Health Field Office
School Health Unit
Hospital
Health Center
State Capital
Regional Office

GPO 843-

ABERDEEN AREA IHS MENTAL HEALTH PROGRAMS

I. DESCRIPTION OF THE AREA

The Aberdeen Area office administers the health programs for Indian populations in seven states: North Dakota, South Dakota, Nebraska and Iowa form a western unit. This western portion is dominated by the Dakotas, where nine of the eleven reservations are located, as well as the Area Office itself. The Great Lakes States of Minnesota, Wisconsin, and Michigan form a Sub-Area, which has its main administrative base in Bemidji, Minnesota. Because there are both geographic and cultural differences that are quite marked, these two divisions will be observed in this presentation of the Area.

A. Geography of the Western Portion Aberdeen Area.

1. Black Hills

For most people in other parts of the United States, the Dakotas are associated with the Black Hills and the Badlands, both located in the western and southern parts of South Dakota. The Black Hills are 2,000 to 4,000 foot mountains lying mostly in the Dakotas but also crossing into Wyoming. They are the eroded stubs of a granite cap forced upward by pressure to a height that was not affected by the glaciers and their melting, which later formed the plains around them. From a distance across the prairies the dark evergreens that cover them look black, giving the hills their name. The canyons, water courses, and rock formations, as well as the evergreen woods, have often invited comparison to the the Black Forests of Germany by travelers who have visited both places. Mount Rushmore, one of the most famous National Monuments, is a granite peak well known for the sculpture of four Presidents carved from the living rock. Not far from Rapid City, at the southern entrance to the Black Hills, a second mountain is being carved into a likeness of Crazy Horse, a famous leader of the Sioux, as a privately funded enterprise.

The Black Hills were originally included in the Sioux Reservations, but in the 1870's George Custer discovered that gold could be mined in the mountains and along the stream beds. This discovery led to a mass immigration, similar to the California and Alaskan Gold Rushes, and the influx of people onto Indian land led to antagonism, bitterness, and fighting which culminated in the great battles of the last Indian campaigns. Custer was defeated at the battle of the Little Bighorn in Montana, and in reprisal the Sioux particularly were driven back into the Badlands and the prairie country in Southern Dakota, where they were confined to much smaller reservations and deprived of claim to the Black Hills. Pine Ridge, which gives its name to one of these reservations, marks the foothills at the extreme southern edge of the Black Hills.

2. Badlands

The Badlands are an eroded formation, probably formed from a very early glacier morraine. which was not covered again by ice and therefore had neither a cumulative buildup of soil nor the smoothing and rounding action which formed the rest of the plains. These rock piles and heaps of clay have been eroded into formations often resembling those of the southwestern deserts. Except for a few watercourses in the canyons, they are dry, arid and not life supporting. The Badlands National Monument is located just north of the Pine Ridge and Rosebud Reservations, but the Badlands themselves stretch diagonally across the length of South Dakota, and into North Dakota and Montana in a strip which varies from six to fifty miles wide. In the northern sections peat and coal, formed from vegetation buried as the glaciers piled up the debris, has caught fire, probably from natural causes such as lightening, and burned for as long as man can trace back in memory. Some of the scorched clay rocks have baked to a brick red which can be crumbled to gravel and which is mined as scoria for roadbeds and building foundations. These Badlands formed a formidable barrier to westward travelers, requiring detours north to follow the Missouri River or south to avoid them entirely. Except for a small portion of the Pine Ridge Reservation, they do not involve any of the present day Indian peoples.

3. Missouri River and Tributaries

The Missouri River dominates the rest of South Dakota and the western half of North Dakota. It enters North Dakota about a hundred miles below the Canadian border and flows easterly and southerly in a curve across the state. After bisecting both states, it forms part of the boundary of South Dakota and Nebraska and the rest of the Nebraska boundary with Iowa. Large dams have been built at intervals along it for flood control and reclamation purposes. The lakes formed behind the dams have flooded parts of a number of reservations, particularly Fort Berthold in North Dakota. Some of the tribes have begun to develop recreational and tourist facilities as tribal business enterprises, but their great distances from heavily traveled routes do not make these a quickly profitable venture.

Fort Berthold in North Dakota and the Lower Brule-Crow Creek Reservation in South Dakota are bisected by the Missouri River, while

Standing Rock and Cheyenne River Reservations are given eastern boundaries by it. The Cheyenne River, following east from the Black Hills, joins the Missouri just below Eagle Butte in the southeastern corner of the Cheyenne River Reservation. A second river rising in the Black Hills and flowing east is the White River which skirts the northern boundaries of the Pine Ridge and Rosebud Reservations, and then curves south to enter the Missouri near Yankton. Yankton Reservation is the only reservation of the chain along the Missouri to lie wholly on the eastern banks of the river.

The Reservations located in Nebraska are the Santee, just a little way below the Yankton Reservation, and the Winnebago and Omaha, just adjacent to Omaha where the Missouri forms the Nebraska-Iowa border. These two reservations are administered as a single unit but both tribes are recognized.

The Sac and Fox, the only remaining Indian group in Iowa, are located at Tama, Iowa, north and east of Des Moines. This tribe lives on land which they have purchased rather than a reservation. While they do receive some IHS and BIA services, there is no active Mental Health Program under IHS sponsorship, so they will not be further considered here.

4. Drift Plains

The casual traveler on a commercial air flight across the northern United States often looks down and erroneously identifies the Minnesota-Dakota border in terms of a sharply defined pattern of neat small fields of widely varying crops as compared with the grassy prairies or vast wheat fields. This is especially noticeable in harvest or plowing seasons. With a generalized knowledge of the massive migration of Scandinavian peoples into Minnesota in the 1850's, the easy interpretation is to identify the tidiness and intense cultivation with more thrifty Minnesota folk, and the wildness and openness of the land to the west to a different culture. Whether or not there would be any basis for this, a student of geography and geology learns that the visible line is actually about one hundred miles west of the Minnesota border into the Dakotas and represents the edges of what are known as Drift Plains, left by the series of glaciers in the series of ice ages. These glaciers melted into large lakes, one of whose beds covers a great deal of North Dakota and northern Minnesota. All of the Drift Plains are rich in alluvial soil and the accumulated organic matter from the lakes and bogs formed by the melting glaciers. Unlike the prairies to the west, they support a wide variety of crops, and small-animal farming (hogs, dairy cattle, etc.) is quite profitable. The Sisseton Reservation, touching the Red River of the north and crossing slightly into North Dakota is one of the reservations that shares this type of rich farm land. In North Dakota the Fort Totten Reservation, adjoining Devil's Lake, and the Turtle Mountain Reservation, adjoining the Canadian border of the Province of Manitoba, both lie on these "young" Drift Plains.

5. The Great Lakes Region

The IHS responsibility for Chippewa and Winnebago tribes in Wisconsin and Minnesota is related to the shores of the northern parts of each state, and to the smaller lakes which remain as the glaciers drained into Lake Superior and the other Great Lakes. In general this is a level fertile region, heavily forested, although some of the woods are second growth after the massive operations of the Lumber Barons of the turn of the century. Resort communities, based on winter sports, fishing, hunting; and vacation cottages are part of the local economy of both states, and are particularly highly developed in northern Minnesota. The Lake Superior Uplands of Wisconsin are not populous, although they are pleasant rolling hills and forests with highly fertile land. Their relative isolation and far northern climate have not tempted a wave of immigration. Mining and forestry are practiced in some degree, but not particularly as an encroaching threat upon the Indian population.

B. Tribal and Cultural Background: Woodland Tribes

1. The Chippewa

The Chippewa, also known as the Objibway, are a large group of Indians in the Algonquian language and culture pattern who originally lived in the Eastern Forests and around the Great Lakes. They were a fishing and agricultural people, and the pressure of their displacement to the west was felt by the Sioux and Cheyenne, who then were also displaced.

The border between the United States and Canada was more fluid in early periods of the settlement of both countries, and the Chippewa moved back and forth freely then, and to some extent still do so. During the French and Indian Wars they were identified as siding with the French, and during both the American Revolution and the War of 1812, they were identified as being supporters of the British. There are many of this tribe in Canada as a result. Although, in general, except for these international episodes, they have never been particularly involved in any confrontations of a violent or military nature with the Americans, there is some lingering feeling that their reservations and benefits have not been enthusiastically and aggressively pursued.

The three reservations in Minnesota, Red Lake, Cass Lake and White Earth represent Chippewa populations and are located in the northern portion of the state not far from Bemidji. This collection of Chippewa are well known for their harvesting of wild rice in the local lakes, and have in some instances formed cooperative marketing outlets for this product which is now becoming popular instead of remaining a luxury gourmet item. Hunting in the Minnesota forests, guiding parties for canoe and hunting trips, and other woodsman's skills are important, together with the development of clerical and trade skills which enable them to enter into general employment.

After the Minnesota uprising of the 1800's, this band has not taken as aggressive a stand as some of the other tribes, but has recently mobilized itself and asserted its prior hunting rights, as well as rights to limit white encroachment on its lands.

One group of Chippewa was displaced by the Sioux and the other influxes of population into the Great Lakes region and are now located on the North Dakota-Canada border at Turtle Mountain (Fort Belcourt). This tribe crossed freely into Canada, and sided with the British in some of the very early tests of strength between the U.S. and the British. Their tendency to claim lands straddling the border was an embarrassment to both countries, but travel is now less noticeable because of the open borders, and the general impression is that the Turtle Mountain population is relatively stable.

Although bordering on the drift plains, which is one of the few regions where farming might be pursued, the continual redivision of land holdings through heirship, as well as sales to non-Indians, does not make farming profitable for the Indians on the Turtle Mountain Reservation.

This reservation is presently too remote to attract tourists, but the tribal government has managed occasionally to develop industrial contracts for small-parts work, which aids in reducing the otherwise chronic poverty. The 1970 Census gives a total population of Rollette County, where the Turtle Mountain Reservation is located, as 11,549; and the Indian population is nearly half of this or 5,862.

2. Fort Berthold: Mandans, Arikaras and Hidatsa

The Mandan tribe was a prolific and prosperous tribe that originally seems to have been located in the prairies of Iowa, Nebraska and South Dakota. They spoke a Sioux language but lived a quite different life style, characterized by sod earth lodges in villages of a more permanent character where they cultivated squash, beans and tobacco. They had been pushed or voluntarily migrated to the northern reaches of the Missouri River by the time Lewis and Clark made their explorations in the early 1800's. George Catlin has made many paintings of the Mandan people which are outstanding records of their way of life and their dress and customs. However, a smallpox epidemic in 1837 almost exterminated the tribe, and it is little known today except for the records of its encounters with these early explorers.

The Arikara, also known as Ree Indians, were contemporaries of the Mandan people, settling further south along the Missouri and its tributaries. They too were displaced, being a Caddoan group from Nebraska, and did not come north until the Sioux drove them there in the 1750's. Their dwellings were also apparently earthen lodges, and their villages stable and permanent.

The Hidatsa, also known as the Gros Ventre, were a Sioux language group established in the Devil's Lake area near the present Fort Totten. However, the eighteenth century pressure of the Sioux tribes from the Great Lakes pushed them across the prairies to the Missouri River banks. Some of them moved even further to Montana.

The Hidatsa and Arikara, like the Manlan, were also nearly annihilated by the smallpox epidemic that apparently was spread by travelers up the Missouri River in 1837. In 1870 the survivors of all three bands were placed on a reservation at the junction of the Missouri and Little Missouri Rivers controlled by Fort Berthold, and they remain there as affiliated tribes. Meanwhile, the Garrison Dam has flooded a large portion of their reservation, and land sales have reduced the original size of the holdings. The 1970 Census gives the total Indian population for the four counties involved in the area as 2,335, and the figures decrease between 1960 and 1970--an unusual occurence for Indian groups at this time.

3. Winnebago

The Winnebago, according to their own tribal traditions, were displaced in a somewhat opposite pattern. Originally, they claim to have lived along the Missouri in the Dakotas, and in the 1600's to have been displaced toward Lake Michigan into Illinois, Minnesota, Michigan and around Green Bay, Wisconsin. They speak a Sioux dialect, and may perhaps reflect the earlier culture of the Great Lakes Sioux who were later displaced to the western plains. They lived in long lodges, used arbors over their dooryards and for summer shelter. They cultivated a few crops of beans and squash but also hunted a good deal of their food.

During the Revolutionary War and the War of 1812, they sided with Great Britain, and by 1830 there were efforts to displace them onto reservations away from the desirable river bottoms and lake lands. Some Winnebago did move north but many wandered first to Iowa, then to Illinois, and finally settled along the west banks of the Missouri in Nebraska. The 1970 Census lists 1,911 Indians in Thurstone County, which is the site of the reservation. Another 1,194 Indians live in Omaha, including many from a wide variety of tribes established there on relocation from other reservations or others who have come on their own into Nebraska looking for work.

The remainder of the Winnebago live in the northern reaches of Wisconsin, mainly around small lakes. They are well known because of the anthropological studies made of them in the early 1900's and by George Deveruex in the 20's and 30's. Services supplied to the Wisconsin reservations are by contract with local mental health resources, negotiated through the Rhinelander Field Office.

C. Tribal Backgrounds: the Sioux Reservations

"Sioux!" It was more than a name for a great tribe of warriors and hunters. In the days of westward expansion, it became a cry of terror which swept across the plains like an echo. Redoubtable foes, the Sioux were rarely vanquished in war. Their defeat came, in the end, not alone by soldiers but by hunger and exposure. . ." This dramatic introduction to a government printing office pamphlet on

Indians of the Dakotas expresses the tension and awe with which this tribe in all its bands is still held by those who read both history and western fiction--or watch the movies or television. The Sioux with their ponies, war bonnets, large bands and teepees, are the romantic symbol of both heroism and villainy in the settling of the west. Yet few people understand their modes of thought and governance, or their present-day predicaments, even though there may be bands among them that are as well studied and described by social scientists as the Navajo in the southwest.

For succinct description, this same booklet condenses the history and characteristics of the different groups of Sioux and locates them on their contemporary reservations. Therefore, it is quoted directly below:

> Although closely and prominently identified in American history with the hills and plains of the Dakotas, the Sioux were not native to the area, but came from more easternly parts. (The name Sioux is a French shortcut for the Algonquin name given these people--Na do wis sue, an allusion to snakes or snake-like movement.)
>
> The Sioux have been identified in the public mind with Indian life in the Dakotas throughout our history, largely because they were in the path of white migrations and resisted them.
>
> The three major divisions of the Dakotas exhibit significant cultural, geographic, and historic patterns:
>
> (1) Eastern, or Santee Sioux, speaking the Dakota dialect, were the last Sioux Division to leave traditional homelands near Lake Superior, and today still proudly consider themselves the original Dakotas. The four Santee subgroups are Mdewakantowan, Wahpekute, Sisseton, and the Wahpeton. They were widely scattered after the Minnesota Sioux Uprising in 1862. Their descendants today live on Fort Totten Reservation in North

Dakota, on Lake Traverse (Sisseton) and Flandreau Reservations in South Dakota, Santee Reservation in Nebraska, Fort Peck Reservation in Montana, and in small reservations in Minnesota.

(2) The Middle, or Wiciyela Sioux Division, who speak the Nakota dialect, were first met by white explorers in north-central Minnesota around the end of the 17th century. Shortly thereafter they moved west, splitting into the Yankton and Yanktonai groups. Members of this Sioux Division are today found on the Yankton and Crow Creek Reservations in South Dakota, and Standing Rock and Fort Totten Reservations in North Dakota and Fort Peck, Montana.

(3) Western, or Teton Sioux "men of the prairies," whose dialect is Lakota, have always been by far the largest Sioux Division, outnumbering all others combined. They are, in addition, the Sioux phototype whose characteristics are most often used in portrayals of the North American Indian. Seven subbands make up this large Division: the Oglala, Brule, Sans Arcs, Blackfeet, Minnekonjou, Two Kettle, and Hunkpapa. Of these, the Oglalas were both the most numerous and the most resistant to white invasion.

Today most of the Sioux population of the Dakotas stems from the Teton Division. All its seven bands are represented in South Dakota, occupying Pine Ridge, Rosebud, Lower Brule, Cheyenne River, and Standing Rock Reservations.

Bands of Tetons, first of the Sioux to wander into the Great Plains, were first encountered by French explorers in the middle of the [illegible] century. Even then, they seem to have begun the change from their original woodlands culture, for early French chronicles had associated them with the buffalo. Yankton Sioux bands, and then the four Santee groups, followed the Tetons west. The Sioux took over vast areas of the wilderness and claimed them as their own. As the 19th century began, they had become the dominant tribe of the Northern Plains.

The bison, or buffalo, was basic to the Sioux economy, providing food, clothing, shelter, and an amazing variety of tools and equipment, as well as sacred objects for ceremonial use. The buffalo was often more than a means of subsistence; it became the center of a Sioux band's culture as well, determining their entire way of life.

The Sioux hunting pattern was similar to that of other Plains Indians.

Acquiring horses--often stolen in raids--they became more mobile. Large groups, sometimes composed of several bands, were able to travel hundreds of miles during the summer chase, carrying their shelters with them. These were tipis, or conical tents of animal hides supported by several poles which also were used as the base of the travois, or loadbearing platform pulled by horses to transport household goods, supplies, and the infants, aged, or sick.

The summit of Sioux religious expression was the Sun Dance, an annual ritual performed during the summer encampment and lasting several days. Among the Teton Sioux and some other Plains tribes, the Sun Dance was climaxed by a form of self-torture in which dancers attempted to pull free from a skewer which pierced their breast muscles until either the muscles or the skin was torn away. The skewer was secured by a rope attached to a central pole 20 to 30 feet from the dancer. This performance was demonstration of the dancer's physical endurance and represented the most powerful of all varieties of Sun Dance vows.

Sioux warriors also sought personal fame on the hunt and in war. For example, to count "coup" by touching an enemy in combat with the hand or stick and escaping resulted in the very highest honor. The counting of "coup" was long remembered and retold at gatherings.

Coming of the Settlers

Although habitually at war with other tribes, the Sioux did not actively resist white immigration until the whites began to intrude in great numbers. With discovery of gold in California during the late 1840's, waves of prospectors and would-be entrepreneurs swarmed over the plains en route to the west. Some stopped half way, and troops were assigned to patrol the region. The Plains Wars began in earnest.

In the years following, Indian attacks had reached a point demanding Government intervention. A great peace council was called near Laramie, Wyoming, with some 10,000 Northern Plains Indians, predominantly Sioux, attending. In the resultant treaty the tribes pledged peace among themselves and with the United States, and promised U.S. citizens safe passage across Indian lands.

Neither side lived up to the treaty terms and in 1855, General W.S. Harney, hero of victories in Mexico, was summoned to command a campaign against the western Sioux. His defeat of a group of Brules led by Chief Little Thunder terrified all Teton bands, and several years of relative peace followed.

Then, in 1862, an event since known as the Minnesota Uprising alarmed Sioux everywhere. Members of the eastern Santee Sioux Division had ceded most of their Minnesota lands in 1851 in return for annuities, supplies, and other considerations. Settlers continued to destroy the Indians' game, however. The Santees asked to be given new hunting grounds in the West, because their normal way of life and means of livelihood were being destroyed by the growing population in the Dakotas.

Supplies were not forthcoming to the Santees as the winter of 1862 set in. They asked for provisions from a private store, and were told by the owner, Nathan Myrick, "Let them eat grass." The Santees then went on rampage, killing Myrick and several other settlers.

Not all Santee groups participated in the uprising and some actually helped the U.S. Army by rescuing white hostages. Nevertheless, the Government retaliated by confiscating all annuities and lands assigned to the Eastern Sioux and sentencing more than 300 Santees to death. (President Lincoln later pardoned all but 38 of these). Many Eastern Sioux fled or were removed to the Dakotas, where they were eventually established on reservations. Some crossed the border into Canada, where their descendants still remain.

The Minnesota Uprising brought renewed attacks by the Sioux upon all travel routes from the Missouri River to the Pacific. Wagons, stages, and telegraph lines were destroyed: travelers and entire white families were murdered: and the frontier became a scene of terror. The Army was moved in, and within months, large bands of Sioux were defeated in several North Dakota battles.

The Sioux were further inflamed with passage by Congress in 1865 of a bill authorizing new routes to the west through the great Teton buffalo ranges. The Sioux considered their very existence at stake if tribal lands were to become a thoroughfare for white prospectors and settlers.

Red Cloud, an Oglala Chief, had become one of the most powerful leaders of the Tetons. As a Sioux spokesman he protested the building of new roads and military posts, but without success. Plans for the new trail to goldfields in Montana and Idaho continued. Red Cloud and his people grew determined to stop the white invaders. Sioux warriors, strengthened by large groups of Cheyennes, were spaced throughout the country from the Yellowstone River to the Black Hills, besieging immigrants, soldiers, and surveyors. Attempts to cross the land became utterly impracticable. In the end, Red Cloud won.

The Fort Laramie Treaty of 1868

Under the Fort Laramie Treaty of 1868, the United States agreed to keep whites from hunting or settling on Indian territory; to abandon the proposed trail west: and to pay annuities for sppropriated Indian lands. The Treaty also established a Great Sioux Reservation which was to include all of what is now South Dakota west of the Missouri River, "for the absolute and undisturbed use and occupation of the Indians named herein." For their part, the Indians were to release all lands east of the Missouri except for the Crow Creek, Yankton, and Lake Traverse (Sisseton) Reservations previously created.

By the end of 1868 nearly half the Sioux were gathered onto reservations, and for 2 years, conditions of the Fort Laramie Treaty were observed. As a sign of the amiability of the times, in 1870 Red Cloud, accompanied by a large entourage of headmen and chiefs, was guest of honor in a much publicized tour which included official and public appearances in Washington and New York.

But during this period, recalcitrant warriors of various Teton bands under Sitting Bull were still roaming the Powder River country of Montana and Wyoming. Construction of a railroad along the Yellowstone River and other treaty infringement set the stage for Indian wars of the 1870's.

In 1874, following glowing and widely-publicized reports by General George A. Custer that gold had been discovered in the Black Hills, prospecting parties hurried toward the Dakotas. The Government ordered soldiers to keep goldseekers off Sioux lands, and military forces stationed at points along the Missouri were to seize and destroy wagons and prospecting outfits. The Sioux, although annoyed with the Army's "invasion" of the Black Hills, remained patient.

Then, in the fall of 1875, several Sioux bands left their reservations with Government permission to hunt buffalo in the unceded Powder River country of Wyoming. They were suddenly ordered to return by the end of January, or be declared hostile. The message, arriving late, found the Indians in severe cold and with almost no food. They were unable to travel, and remained quietly where they were. As a result, Oglala Chief Crazy Horse and his camp fell under an attack by General George C. Crook. The Sioux escaped to the hills, but in the following spring, Crazy Horse and his men came out of hiding to defeat the U.S. Army in several encounters, climaxed by a decisive victory over General Crook in the Battle of the Rosebud. Crazy Horse then moved north, joining Sitting Bull with the main body of Sioux and Cheyennes.

The Army faced formidable adversaries in Crazy Horse and Sitting Bull. Crazy Horse was reputed to be the military genius of the Sioux Confederacy. Sitting Bull, although not a war chief, was a medicine man of great influence.

After the Battle of the Rosebud, the Army realized that defeat of the Indians was a bigger undertaking than expected. New tactics were planned and the 7th Cavalry under Custer was sent to find the Indians' encampment.

Custer's Last Stand

General Custer and his men moved into the valley of the Little Big Horn on the morning of June 25, 1876. His Crow scouts had sighted Sioux campfires at dawn, but Custer, making a mistake common to U.S. military leaders of the time, underestimated Indian strength.

Custer's famous "last stand" was brief. Within an hour or two, he and his entire command were annihilated. Several miles away the other two columns under Reno and Benteen continued to fight a second day until the Indians, sighting a relief column, disappeared into the hills.

The Battle of the Little Big Horn was the last great Sioux victory. Scattering throughout the country after their triumph, the Indians were run down and defeated, band by band, by U.S. Army forces. Beaten, disarmed, and dismounted, they had no choice but to accept the terms of an 1876 agreement under which they at last relinquished not only the sacred Black Hills, but the long-fought-for Powder River and Yellowstone buffalo country as well.

Tension on the Reservations

In the 1870's, buffalo herds were systematically slaughtered by white commercial hunters. With the appalling destruction of the buffalo, the food supply disappeared and the tribes were forced to accept reservation life and rationed food. One after another, Sioux chiefs surrendered. In 1877, Crazy Horse came out of hiding and surrendered to his old adversary, General Crook. The Oglalas settled at Pine Ridge. In 1881, most of the Sioux bands who had escaped to Canada under Sitting Bull following the defeat of Custer returned to the United States under Gall, surrendered, and were taken to Standing Rock Reservation. Late the same year, Sitting Bull, too, returned and gave himself up to the U.S. troops.

Confined to reservations, unable to hunt or fight, betrayed by broken treaties and forbidden by the Government to seek supernatural help through the Sun Dance, the despairing Sioux turned to a new cult, the Ghost Dance. Started by a Painte prophet who claimed to have received a message from the Great Spirit, the Ghost Dance spread like wildfire through the reservations.

The new religion called for dances and songs which would hasten the return of the buffalo, the arising of Indian dead, and the disappearance of the white man. It was harmless, in that it promised these things by supernatural means, and ruled out violence, but white settlers feared it as preparation for new Indian hostilities. As 1890 drew to a close, nearly 3,000 troops had been called into Sioux country to maintain peace. Frightened at the military concentration, some Sioux bands who had joined the Ghost Dance cult abandoned their reservations and were branded as "hostiles."

The Sioux 'Last Stand'

Late in December 1890, troops from the 7th Cavalry intercepted a group of Sioux under Chief Big Foot on the Pine Ridge Reservation where they had fled after Sitting Bull was killed. About 20 miles northeast of the Reservation, the party stopped and pitched camp at Wounded Knee Creek, where they were joined by four additional troops of the 7th. Sioux tipis were entirely surrounded by soldiers, and guns were trained on them from a nearby bluff.

Ordered to surrender their arms, the Sioux warriors produced only two rifles, and soldiers then entered and searched Indian tipis.

There was a rifle shot. Soldiers at once directed their Hotchkiss guns at the Sioux warriors. Some of the survivors of the first gunbursts fled in panic, pursued by hundreds of soldiers and raking gunfire. Bodies of women and children were found scattered as far as 2 miles from Wounded Knee, slaughtered in flight after all Sioux resistance had ceased.

> Within a few days after the Wounded Knee Massacre of December 29, and some sporadic fighting at the Catholic Mission and the Indian Agency, the remaining Sioux refugee bands came in from the Badlands to surrender. The tragedy ended for all time armed and overt opposition, and they began their long and difficult road to a new life.

The current events on the Pine Ridge Reservation, especially the 1973 events at Wounded Knee, belie the statement in this last paragraph somewhat. Certainly both the United States and the Sioux were ready to pick up old reflexes again, and new fires seem to be smoldering--as much in pitting Indian against Indian as in a struggle of Indian against white man. A final quotation from the booklet puts this history into better perspective: "The struggle to build a new life has been a long one, fraught with reversals. The Indians of North and South Dakota are today a people in transition between a time lost forever, but still recalled with bitterness, and a time yet to come when poverty and isolation will no longer scar the living."

II. DEVELOPMENT OF MENTAL HEALTH SERVICES AND PROGRAMS: SOCIAL SERVICE BRANCH 1955 - 1965

There are three threads in the skein that represents Mental Health Programs and Services development in the Aberdeen Area. The first is the continuous interest and activity of the Social Service Branch from the 1950's and the establishment of IHS. The second is the somewhat independent and certainly unique program that developed on the Pine Ridge Reservation beginning around 1965 and included in the original appropriation for IHS Mental Health Programs in 1966. The third strand, which has been introduced in the 70's, has been the expansion of staff, programs and funds to other Service Units and Reservations in the Area and the eventual merger of Social Services and Mental Health Programs at the Area level. Before describing the contemporary activities at the Service Units of the Area, each of these threads will be identified and traced from the time of origin to the present.

A. Initial Programs: Robert Leon, M.D., and Lucy Ozarin, M.D.

The involvement of IHS in Mental Health related activities in the Aberdeen Area dates back to the formative period when IHS itself first became a separate entity under USPHS. At that point in time, it was decided that the former practice of sending USPHS personnel to Indian Reservations and Schools to work under the BIA was not permitting effective development of health programs. This was in large measure due to lack of experience on the part of BIA staff with the complexities of health program administration, and of the needs for developing health programs. The difficulties of personnel from one arm of the government being administered by another were insurmountable, and the special group known as the Division of Indian Health of USPHS was formed and given charge to care for the health needs, both treatment and prevention, of the Indian people. This was interpreted as meaning those Indian people residing on the reservations and the children and youth attending federally supported boarding schools.

In the fall of 1955, as this new regime began, the USPHS physicians in the Aberdeen Area Division of Indian Health met regularly, once a month, in seminar, to deepen their understanding of the Indian people they were serving, and to discuss and share problems in developing treatment plans and communicating with both communities and patients. These seminars were led by Dr. Robert Leon, Community Mental Health Branch Chief from the HEW Regional Office in Kansas City, with the assistance from time to time of a clinical psychologist and a psychiatric social worker from that office.

During the course of these seminars, Dr. Leon became particularly interested in the problems that were apparent at the Indian boarding schools. He met a number of times with the various staff members of the BIA Educational Branch and with school personnel at Flandreau Indian School. Dr. Thad P. Krush of the Nebraska Psychiatric Institute at Omaha, Nebraska, was enlisted as a consultant and made a number of trips to Flandreau School as early as 1955.

In 1956 the BIA developed annual summer workshops for boarding school faculties and dormitory staff, and utilized these resources for the discussions of mental health programs, which were always a matter of significant concern. IHS supplied the resource people for this topic and was instrumental in securing outside assistance from NIMH and from Dr. Krush and his staff. When Dr. Leon moved to another region (Dallas), his successor, Dr. Lucy Ozarin, continued the contacts with the Aberdeen Area Indian Health staffs, although formal seminars were discontinued. Dr. Ozarin and her staff did assist in holding a significant number of workshops for nurses, public health nurses, social workers and other staff, and short workshops for physicians from time to time.

In 1957 the scope of these workshops was expanded to include one conducted by Dr. William Hollister from NIMH at Pine Ridge. This workshop included not only BIA staff but also Mission School and public school staffs who had Indian pupils. NIMH was instrumental in securing the field consultation from its staff anthropologists, especially **Dr.** Thomas **Galdswin.** The anthropology field visits included not only reservations but also boarding schools. Recommendations were made to IHS about ways in which the IHS could better meet the needs of the Indian people. Unfortunately, copies of these field visit reports have not been made available for inclusion in this documentary history of Mental Health Program development.

B. Canton National Insane Asylum Aftermath

For many years the federal government had operated a national Insane Asylum for Indians at Canton, South Dakota, which received patients not only from the Aberdeen Area, but from any reservation. This little-known institution played a fairly interesting role in psychiatric history since Krapaelin visited there in 1927 and utilized the visit to attempt to establish some of his theories about the origin of syphilis based on the low incidence of syphilitic general paresis among the patients in comparison to the reported prevalence of venereal disease among the Indian population.

Dr. Leo Kanner, who was at the South Dakota State Hospital at Yankton in the early 20's, also had some experience with American Indian patients, and this may have had some influence on his later development of theories for the treatment and diagnosis of autism.

In the early 1940's the hospital building at Canton was condemned as unsafe, and it seemed as though better psychiatric care could be provided through the

federal hospital, St. Elizabeth's, in Washington, D.C. One hundred and eleven patients were transferred to St. Elizabeth's, and during the intervening years the BIA sent a number of additional patients from the Aberdeen Area. It was not until 1952, shortly before the formation of the Division of Indian Health Services, that negotiations to utilize state hospital facilities were initiated. Although occasionally an Indian patient would arrive at the state hospital, usually because of residence in town or being picked up by law enforcement officials off the reservation, they were held only until identified or occasionally for a brief diagnostic study to be completed.

In 1956 the staff at St. Elizabeth's made the decision, with IHS concurrence, that Indian mental patients would be better served by being hospitalized or treated in their own communities. About forty patients whose original homes had been in the Aberdeen Area were identified among those in the ward at St. Elizabeth's. In a period of two or three years all but one of these had left St. Elizabeth's and had been placed by IHS social services and physicians. Among the facilities used were state hospitals and nursing homes. Some were returned to relatives who could care for them with IHS supportive follow-up. A few died during or shortly after this transition. Interestingly enough, most had been at St. Elizabeth's since 1942 and few had had any contact with their families or any of the agencies in the Aberdeen Area during the fifteen or more years stay at St. Elizabeth's. The impact of this experience on both IHS staff and on the tribes and families whose lives and relatives were affected has been one of the threads that keeps interest in mental health activities alive in the Aberdeen Area and motivates development of local programs.

C. Flandreau Boarding School Project

Until 1977 Social Services had been chiefly oriented toward medical social work. However, in that year the first psychiatric social worker was employed in the Aberdeen Area. John Bjork, M.S.W., was recruited and assigned to the Flandreau School. This was in response to the BIA's urgent request for help with the many and serious mental health problems presented by their student body. A regular consultation contract, utilizing the services of Dr. Thaddeus Krush from Nebraska Psychiatric Institute, provided additional specific mental health service to the Flandrean School for a period of several years.

In 1962 NIMH funded a three-year project which Dr. Krush and Mr. John Bjork, MSW, co-directed and which expanded their services to all off-Reservation Boarding Schools (Pierre and Flandreau in South Dakota and Wahpeton Sharpkes in North Dakota) in the Aberdeen Area. Additional staff included social workers, consulting psychologists, sociologists and anthropologists. Basic documentation of the needs for changes in the BIA Boarding Schools and the types of problems encountered with pupils was developed as part of the research base of the service delivery program. This material was published and remains the definitive and basic study of contemporary needs of BIA Boarding School pupils and staffs. Unfortunately, Dr. Krush died suddenly before the final report was prepared. Mr. Bjork completed the work and became the full director of this project. Like many special or pilot projects, once the funds supplied by NIMH were exhausted, it was difficult and, in fact, impossible to continue the program in its original form. The BIA and IHS have continued to have boarding school problems very much in awareness, but many of the recommendations from this study have yet to be implemented.

D. Deputy Social Service Chief for Mental Health:

John Bjork, M.S.

In 1965 John Bjork, having completed the Flandreau Project, had also accumulated considerable expertise in the intricacies of developing Mental Health Programs within the IHS system. He was transferred to the Aberdeen Area office and within the Social Service Branch was delegated the responsibility for Area Mental Health activities. His experience was immediately put to practical use as he developed consultation contracts at the three BIA Boarding Schools to keep alive as many of the innovations and recommendations of the NIMH project as possible. These consultations were funded through Contract Health Services of IHS, as were consultation contracts to both Sisseton and Fort Yates on the Standing Rock Reservation.

In addition, Mr. Bjork worked closely with the community mental health facilities; and as CMHC's were formed, he persuaded many of them to expand their plans and to include the Reservations in their catchment areas. Some of these activities form the basis for the present contract programs in Minnesota, Wisconsin and Nebraska, as well as for continuing relationships throughout the Dakotas.

The Social Service Branch also had responsibility for administering about $300,000.00 per year in funds to provide for in-patient care at the various state hospitals, between 1969 and 1971. Relationships with state hospitals improved markedly. These relationships remain open in spite of the ruling that was made in 1971 that payments to state institutions should cease on the grounds that Indians were entitled to the same care at state institutions that other citizens receive. This delicate issue is noted in several other Areas and has been variously resolved. However, it is doubtful if all the states involved in the Aberdeen Area would have accepted this ruling without Mr. Bjork's active role in bridging relationships between IHS and the state systems. As a matter of interest, since Mr. Bjork's departure to Oklahoma the state governments of both North and South Dakota have sought to reverse this ruling.

Throughout this period Ms. Betty Glasow, M.S.W., Chief of the Social Service Branch was highly supportive of Mental Health Program development and worked closely with Mr. Bjork, who served as her Deputy Chief of Social Services. In 1972 Mr. Bjork was transferred from the Aberdeen Area to become Chief of Mental Health Programs in the Oklahoma City Area.

III. PINE RIDGE COMMUNITY MENTAL HEALTH PROGRAM

A. 1965-1966

At the level of the Department of Health, Education and Welfare and the Washington, D.C. headquarters of the Division of Indian Health, Marion Andrews pursued a continuing interest in mental health activities. Mabel Ross, M.D., attached to the Chicago HEW Regional Office, had also been keenly interested in the earlier efforts to establish appropriate services in the Aberdeen Area, and for other reasons was particularly interested in Pine Ridge Reservation. This reservation has been studied by anthropologists and social scientists perhaps as much as any Indian population in the U.S. It is accessible from Omaha, Nebraska; Sioux City, Iowa; or from Rapid City, South Dakota, and yet is isolated enough to meet most standards for a research population. It is also a convenient size. (Earlier records estimated its population at around 8-9,000. A careful census completed in 1968 defined the population as 10,000.) One of South Dakota's congressmen, Benjamin Rifel, was a native of the reservation knowledgeable in the mental health field and was keenly interested in securing help for his people. The Lakota Health and TB Association, an all-Sioux group expanded their interests to include Mental Health as the peak period of tuberculosis epidemic passed. Mrs. Eunice Larabee was particularly influential in this transition.

Beginning in 1965 under consultant leadership of Dr. Ross, a project was planned which would develop a "model program" within the Pine Ridge Service Unit, introducing mental health personnel at a service delivery level. It was hoped that the Pine Ridge program would demonstrate the way this might be accomplished in other Service Units and Areas of the Division of Indian Health, as IHS was then called. The projected plans for this effort have been included in the overview chapter, since in many ways they represent a major theme, if not blueprint, for the later development of mental health services throughout IHS. In point of fact, in 1966 the same budget was appropriated for the single mental health program of Pine Ridge Reservation as was appropriated for the IHS Mental Health Program for the whole state of Alaska. This Pine Ridge Mental Health Program was planned as if it were independent or and parallel to the other efforts of the Aberdeen Area IHS Office for a number of years.

Planning and executing the mental health program in the Pine Ridge Service Unit was in some ways a much simpler task than implementing programs on an Area-wide basis. The Pine Ridge program was independent of the Area Office in terms of budget which was congressionally appropriated. Geographically the territory covered by Pine Ridge Reservation was more compact than either the Alaska or Navajo Areas. Although the reservation is roughly 50 miles wide and 100 miles long, there are roads connecting established communities with which to work. There was a single hospital, located at Pine Ridge, and a secondary resource in the Sioux Sanitarium, located in Rapid City just off the reservation to the north. As on the Navajo, there was a single language group and tribe, for the most part, although a few members of other tribes had either married into the Oglala Sioux or had come there to live for other reasons. Most of these non-Oglala Indians were from the adjacent Rosebud Sioux Reservation, of approximately equal size and to the east, and therefore shared a language and cultural background quite similar in many respects.

Built into the original Pine Ridge program were two aspects of service to be delivered:

> The primary objective was to assist the medical and other IHS staff and to become a resource for them in learning to understand the people whom they had a mission to treat.
>
> The second objective was the provision of mental health services of a preventative as well as clinical nature.

The size of the budget in relation to the population was justified by designating a large proportion of time be spent in research into the characteristics of the population, the nature of their problems, and the potential remedies available. The clinical services of the already established Social Worker staff were expected to continue and to integrate with the new Mental Health Program. The only other clinically trained person in the original staff was the psychiatrist, Carl Mindell, M.D. In time anthropologists, sociologists, nursing and clerical staff were recruited, while social work staff both recruited and transferred from within IHS.

B. Overview of the Pine Ridge Mental Health Program in its Early Phases

By the fall of 1966 minimal staff were located at Pine Ridge, and work on the development of the model program began in earnest. The first quarterly report of this staff sets forth the goals and services in some detail. Dated October 11, 1966, the report tersely states that the Public Health Service Mental Health Project was situated in a trailer house behind (northwest) of the Pine Ridge Hospital and that the initial staff were Dr. Carl Mindell, psychiatrist, Miss Dorothy Gill, M.H. Nurse Consultant and Mr. Miller, Psychiatric Social Worker. The pages depicting the goals and services provided are quoted in full below:

> IV Goals
> 1. The major emphasis of the program was to be on prevention of Mental Illness rather than cure.
>   a. We were to organize a system of detection of situations indicative of possible mental illness, e.g.
>   repeat court offenders
>   problem drinkers
>   suicide attempts
>   slow learners
>   accidents, etc.
>   b. We were to be involved in teaching Mental Health principles.
>   c. We were to develop means of helping other community caretaking agencies to coordinate resources.
>   d. We were asked to develop guide lines so that a Mental Health program could be extended to other Service Units.
>
> V. Services Provided
>   A. With regard to prevention of mental illness and early intervention:
>   1. Consultation to schools
>   a. In a situation where a teacher feels a child shows signs of being emotionally disturbed.

We hope to:

1. be of help to the teacher in handling this problem and because of this one, similar problems thereafter
2. we hope to be of help to the child, if needed and also to his family- because- signs of emotional disturbances in a child often indicates family disorganization.

b. Consultation to groups to teachers on problems they want to talk about. This consultation is provided to all schools on the reservation with the mental health consultant visiting the school regularly at weekly to bi-weekly intervals.

2. Consultation to Physicians, Nurses, PHN's and other hospital personnel.
   - a. The consultation e.g. with the physicians is aimed at helping the Dr. with this particular case and hopefully others in the future similar to it. Often times the patient is seen and evaluated and then referred back to the original physician with recommendations as to treatment. This is not done if the physician feels he does not want to or cannot treat this particular patient. On-going help with the patient is open to the physician.
   - b. Topics of general interest are discussed with the physicians at intervals.
   - c. The psychiatrist attends medical and pediatric ward rounds for on the spot consultation if needed.
3. Consultation is provided to other community caretaking agencies: This includes:
   - a. BIA Welfare
   - b. State Welfare
   - c. Law and Order
   - d. Clergy
   - e. OEO Components
4. In addition we are involved with what we might call consultation to the Community.
   - a. We spend time in each community attempting to further understand the needs of the community especially regarding Mental Health needs.
   - b. We attend the communities organizational meetings and community action meetings.
   - c. We are involved with helping to define problems and to plan for meeting needs e.g. with regard to the problem of abandoned, neglected and delinquent children.

B. We are involved with a 24-hour around the clock psychiatric emergency consultation service.

C. With regard to inpatient hospital treatment of psychiatric patients we have hospitalized a few patients who have needed acute, short term care.

One of our beliefs is that a patient in need of psychiatric care should be able to receive it at home (when appropriate) or as close to home as possible. We hope that our program will allow patients to receive treatment in their community rather than going to the State Hospital. So that in-patient services would be involved here as well as the next category of patient service.

D. Out-patient Services

This aspect of our services is primarily aimed toward crisis intervention rather than toward the alleviation of chronic problems.

1. We offer diagnostic evaluations and recommendations to walk-in clinic patients. This includes total family diagnosis in the case of kids.
2. We provide brief, goal limited, crisis focused psychotherapy.
3. We offer very limited long term psychotherapy.
4. We are beginning a program to deal with the need for services for alcoholics. At this time the program revolves around treatment by the general physicians with the use of the drug Antabuse.
5. Where appropriate we try to keep a patient in the community by coordinating community resources to help the patient.

E. We are involved with various studies:

1. Studying the rate and morbidity involved with accidents and trauma.
2. Juvenile first offenders with Law and Order.
3. Survey of diabetic patients - to help plan for the patients.
4. Study of State Hospital referred patients in order to improve our after-care services as well as preparation for hospitalization.
5. Study on AMA's designed to pinpoint factors involved with people who sign out against medical advice. This study will involve both the patient and hospital personnel.
6. Study of the problems of indigenous aides.

F. Other activities and community services.

1. Monthly or bi-monthly the Community Mental Health Program plans and sponsors a 2-day seminar on some topic related to Mental Health. These programs are usually conducted by an expert in the field, either locally or is brought in from the outside.

   Previous seminars include:

   a. Understanding the Sioux People-Leader: Rev. Noah BrokerLeg.
   b. Normal Growth and Development-Leaders: Director of Headstart Program and Pediatrician.
   c. Communication with Families-leader: Mrs. Virginia Satir.

d. Sioux Values and their Relation to Educating the Sioux Student-leader: Rev. John Bryde of Holy Rosary Mission.

2. We are involved with collecting data about what we are doing and in evaluation. For this purpose we are using McBee Keysort cards to collect and to have available quickly information for research purposes.
3. We are involved with maintaining a Pre-School Child Health Register begun by the former hospital Pediatrician, Dr. McCracken. This register will allow us to identify health problems, guide in program planning and measure results.
4. We have published monthly and will publish bi-monthly a report of our activities.

G. Future Plans

a. Psychiatric consultation to the Sioux Sanitorium in Rapid City, S.D.

b. Involvement of Community Health Aides in Mental Health work.

Since the Pine Ridge Mental Health Program had an autonomy which preceded the appointment of a psychiatrist and continued for many years, it is difficult to pinpoint changes that might be due to the administrative leadership of a single person. In other Area narratives it will be possible to divide the narrative into approximately two-year intervals and develop a chronology keyed to the senior staff. However, in the Aberdeen Area the work of Mr. Bjork in developing contracts for mental health consultation to other service units was proceeding in parallel with the full-scale development of the Pine Ridge Mental Health Program.

The fuller staff and more diversified approach, which included research as a staff activity, is a distinctly different way of organizing a program. Fortunately the Pine Ridge program also published its work in a series of reports beginning in 1967 and running through 1971, which permits an overview of their extensive and intensive efforts to understand the Oglala Sioux and the problems faced by the reservation and Service Unit. A summary of these bulletins over their entire five year period of publication, organized topically, gives some of the highlights of this aspect of the program.

C. Highlights of Research Bulletins and Publications

1. Census and Baseline Sample Studies: THAT THESE PEOPLE MAY LIVE

A basic portion of the program planned for Pine Ridge Community Mental Health project was to develop an accurate base for planning through knowledge and research into the characteristics of the population. For this reason its staff included anthropologists and sociologists or social psychologists from the first planning stages. Considerable energy and attention was paid to the collection of records in a format that would enable not only contemporary analysis but also future comparative studies to be undertaken.

One of the problems that has plagued planners from nearly every other Area and Service Unit is the inconsistency of census material. There are federal decennial census figures, tribal rolls, and other estimates of population, but really hard data on which one can rely for calculating epidemiological and demographic fractions are simply not available. To remedy this, the Pine Ridge staff undertook a careful and complete census and baseline sampling of the entire population of the reservation. This was a mammoth undertaking, and could not have been accomplished without the cooperative assistance of two other agencies active on the reservation. The BIA provided its most current [illegible] rolls which served not only as a basis for planning, but, after the first wave of interviewing, as a check upon omissions and inaccuracies. The actual interviewing was done by a corps of personnel recruited and trained by the OEO and who were therefore local, Oglala Sioux for the most part, and were able to add their local knowledge to the complex tasks of locating households and securing cooperation. The coordination of the census, the design of the interview instruments, some of the training of field workers, and the analysis of the findings were responsibilities of the Pine Ridge Mental Heelth staff.

The results of this study were the definitive description of the population of the reservation as 3/4 Indian, and 1/4 non-Indian, with a total of 13,500. The 10,000 Indian, almost 99 and 44/100 Oglala Sioux, are given most attention in the analysis of results, but appropriate comparisons of age, sex, educational level and economic activity are made between Indian and non-Indian populations.

One adult in each household, approximately 1,000 persons, was chosen for a more detailed interview in the Indian population. Similar sampling was also done among the non-Indian population. The resulting descriptive analysis, together with a fairly detailed history of the tribe and its reservation, were published in DHEW publication HSM 72-508 entitled That These People May Live: Conditions Among the Oglala Sioux of the Pine Ridge Reservation, by Eileen Maynard, Anthropologist, Gayla Twiss, Research Assistant, 1970. The authors caution the reader that while the facts are accurate, the opinions expressed are personal ones. As well as being a routine formality, this statement provides a tentativeness that is probably appropriate in the sections in which they suggest remedies for the problems uncovered. However, it is of considerable interest to note that this reservation, one of the most studied by anthropologists and social scientists in the last half century, has yet to have most of its planning and recommendations validated by those agencies which have requested the information. Differences between this reservation in historical background, tribal characteristics and accidents of economics notwithstanding, this report stands as the most complete documentation of characteristics available for any tribe. However, it is not clear how many others have tried to utilize its framework to identify their own differences. Even more mystifying is how in the long stretch of years IHS intends to utilize these data locally to provide better programs and more effective services.

Because the information is available in printed form in both the basic volume cited, and in the various research bulletins published by the Pine Ridge Mental Health Project, only a few highlights will be cited here. One of the striking findings was the verification of two large groups in the population known and self-identified as Full Bloods and Mixed Bloods. The term Full Blood may originally have intended pure blood strains, but no longer in reality identifies persons according to blood quanta. Instead it refers to a group, largely rural in residence, who have maintained the Lakota language and the traditional customs of relationship and belief. This group surprisingly enough is more bi-lingual than the Mixed Bloods. Only .3% of the population has no knowledge of English, although 6% might be said to have an imperfect knowledge and use of this language. However, 35% of the Mixed Blood group neither speak nor understand Lakota. In 63% of the homes both Lakota and English are spoken in varying degrees, and in only 5% is no English used at all. As might be expected older persons and the very young are least fluent in English, and many are more comfortable in Lakota at all age ranges.[Following page numbers refer to That These People May Live]

One might have expected that the Mixed Blood/Full Blood groups would provide differential rates of delinquency, divorce, and other social indicators of cultural and social conflict, but it was found that the better division for this purpose was between employed and unemployed. The employed persons show characteristics that cluster around white middle class standards, whether Full or Mixed Blood. This employed population is less vulnerable to mental illness, and to social disorganization. This is a far from comforting finding when one realizes that even when the housewives, the retired, the disabled, and students of appropriate ages are removed from the potential labor force, the unemployment rate on the Pine Ridge Reservation was 36.6%. Furthermore, of those who were counted as employed, 13% had temporary jobs, and 73% were working on a temporary basis. (p. 60) In fact, in 36% of the Indian households no one is working as compared to 12% of the non-Indian households. (p. 61) The corresponding poverty is shown in the accompanying table (p. 62) together with the population pyramids which show age distribution on the reservation. Some income is derived from the lease of lands through the BIA to non-Indian users, mainly ranchers. Otherwise the welfare departments of the state and the general assistance of the BIA provide minimum subsistence to this population. The problem of solving the issues of dependency in a population forced to subsist upon lands which will not sustain them, and where industrial and other development seem of little prospect is a complex one, which must be comprehended to understand the lives of the people. Furthermore, solutions will probably be equally complex, and are far beyond the scope of the mental health program to initiate or provide. It is against this background that one needs to read the record of the work undertaken and accomplished by the Pine Ridge staff. Otherwise, the reports of the establishment of community programs, the clinical description of cases, and the other activities presented seem disarmingly like those of any Community Mental Health Center, and one is inclined to wonder why greater progress, more effective changes, have not occurred; or why the programs are even noteworthy except as more evidence of the efficacy of community health practices.

2. Other Surveys

Other Pine Ridge data are also included in the Pine Ridge Research Bulletins which began publication in 1968, and appeared as often as reports could be gathered together in this format. They include descriptions of YUIPI ceremonies, Sundance participation, Peyote Rituals, and other valuable firsthand accounts of tribal customs and traditions. They also include reports of various sections of the research carried out by the staff and others on the reservation in fairly complete form. These materials, together with the regular quarterly reports to the Area Office of IHS provide a detailed picture of the activities of the staff and their findings. A circulation of about 500 per issue was maintained while they were being published (through about 1971), and the following material summarizes the highlights of much of this content. Focus in this material is on the mental health activities of the staff, particularly with reference to the Goals stated in their initial publications, and covers roughly the period 1966-70. For convenience the material is arranged topically rather than chronologically, although activities in each of of the major categories were being carried on simultaneously.

a. Survey of Attitudes of Teenagers

A study of a small sample of high school students was undertaken at the suggestion of the Oglala Community School Guidance Department. A non-Indian control group was also interviewed.

Eileen Grennell, who was the occupant of one of the two OEO funded Mental Health Aide positions, acted as program research aide during this period. She was responsible for the interviewing and some aspects of coding.

Findings indicated that a high degree of ambivalence toward formal education was a generating stress among Indian students. Parents were missing more frequently from Indian than non-Indian students' families. A most alarming finding was the degree to which Indian students seemed to have accepted a negative stereotype of the Indian; the Indian as being drunken, uneducated and lazy.

A series of recommendations arising out of this study is quoted from Pine Ridge Research Bulletin No. 1.

> In order to stimulate learning motivations we suggest:
> 1. Decreasing the emphasis in Indian schooling on

helping the Indian student get into the mainstream of American life. This philosophy so often seems to lack positive concrete meanings and tends to the negative direction mainly to deemphasize Indianness. There are several interesting experiments going on in Indian education in this area, namely at the Rough Rock School in Rough Rock, Arizona and in Father John Bryde's course on "How to Be A Modern Indian" at the Holy Rosary Mission in Pine Ridge.

2. More research is needed on the relation of parental involvement and power in the educational system and the child's scholastic achievement. At the present time available evidence indicates a positive correlation so that parent involvement should be seen not just as something nice to do to increase communication between teachers and parents but as having a direct relation to the child's achievement.

3. Since the dropout peak occurs between the 8th and 9th grades and after moving to the boarding school during the 9th grade we suggest an orientation program for the 8th graders going to the boarding school of at least a year in duration, beginning at the start of the 8th grade and involving trips from the districts to the school and staying at the school. This should include both prospective students and parents and be followed by discussions of their experiences. This experience should be on-going throughout the 8th grade year.

To help the student through his initial separation experiences from home, a system of Big Brothers and Big Sisters could be set up. Here 12th graders could be given responsibility for introducing the incoming 9th graders to school life. The 12th grader should know the 9th grader he is to work with before they get to school. This also would be an on-going experience for the 9th grader.

4. Adult education needs to be emphasized. Here we are thinking especially of meeting the needs of those who wish to pass their High School Equivalency tests after having previously dropped out and for others to move up the educational ladder.

5. Efforts should be made to involve Neighborhood Youth Corps dropouts and non-dropouts in social service jobs rather than menial, unproductive, bottom of the ladder jobs that no one else wants and which only help to increase one's sense of inadequacy rather than opening up one's potential

6. The Tribal Council should be encouraged to change the Law so that it would be obligatory for Indian students to remain in school until they have been graduated from high school or are eighteen years of age.

b. Study of Orientation Problems of New Staff

The Mental Health Team was involved in a rather informal study of adjustment problems of Service Unit staff to the reservation. The findings are obviously generalizable to other reservations as well and are quoted here in part, from a memo of May, 1966.

> Adjustment to reservation life poses a personal problem for most professional people and their families, particularly the first experience with it.
>
> Many aspects of life on Pine Ridge Reservation are different from those encountered by personnel before coming here. Housing and getting settled may be the first problem. If the individual or family is fortunate there is a place to live and when household goods arrive they can get settled. If the TV or any other electrical appliance requires repair, the owner will need to know where such services are available. Can service be obtained from Rushville, Nebraska (22 miles), or must he go to Gordon, Nebraska (38 miles) or will it be necessary to go to Chadron, Nebraska (60 miles), Hot Springs, South Dakota (60 miles) or Rapid City, South Dakota (115 miles)?
>
> Groceries can be bought at Pine Ridge and White Clay, Nebraska (2 miles) and also over the counter drug items such as aspirin, band-aids, etc. Some hardware supplies are available at White Clay, but prescription drugs can't be obtained closer than Rushville. Newcomers need access to other people, who can guide them in efforts to purchase goods and/or services. Methods of problem solving utilized heretofore are inadequate on the reservation.
>
> Most professional people who come into the Division of Indian Health for the first time are from a metropolitan area and both husband and wife have been able to participate in professional and/or lay organizations of one kind or another. Until recently Pine Ridge offered little other than individual hospitality, but now there is an informal commissioned officer's club. Commercial activities such as motion pictures, plays or concerts have been easily available until coming to Pine Ridge.

Several suggestions to offset this social vacuum have been made to encourage participation among personnel of Division of Indian Health, Bureau of Indian Affairs and Oglala Sioux people. A variety of activities is needed from which personnel could choose. Since wives feel it most keenly because they are not working, possibly an American Association of University Women Chapter could be started since it allows a range of program choices for local groups. An Audubon Society Chapter would offer a neutral ground for wide participation in observing and understanding nature directly during the summer months and by showing films during the winter months. Other activities might be potluck suppers and picnics including all categories of Pine Ridge families. An unanswered question is: with the turnover of personnel would there be sufficient continuing leadership for such activities? On the other hand, if leadership can be maintained, would there be less turnover?

Another problem looms large for families with young children--that is a supply of dependable baby sitters. With the anxieties and uncertainties encountered by young parents entering upon reservation living, such services are particularly important in order for them to feel comfortable about leaving their children to participate in evening activities. Much of the problem stems from the reluctance of newcomers to employ Indian baby sitters.

The unmarried employee, even though working, may also have a problem with finding out where to buy goods and services and unless really able to make friends quickly may be even more lonely evenings and weekends than wives of employees. Professional nurses, for example, must have transportation just to maintain a supply of necessities and to get anywhere for other reasons. Pine Ridge has no commercial transportation available; no bus, no train, no plane. Stage coach services were discontinued in the early part of this century.

As long as professional staff must accept mediocre housing, Pine Ridge Service Unit will have trouble recruiting and holding professional personnel, unless they have a missionary bent for health work or are Indian and consider the reservation home. There is an urgent need for non-government rental housing at Pine Ridge.

The wife of the senior dentist, Mrs. Swain, has volunteered to chair a committee of wives to help newcomers, much as members of American communities abroad have done. One family will assume responsibility for assisting each new family with early adjustments to Pine Ridge, both physical and psychological and hopefully spontaneity will be maintained in these relationships.

The following comments were made during interviews with newcomers:

"The brochure I received about Pine Ridge doesn't even come close to describing what it is really like."

"It doesn't seem like being in the United States."

"Personnel here seem as defeated as the Indian people themselves."

"Pine Ridge doesn't seem like a community but more like a lot of isolated individuals and families unrelated to each other."

Comments from some "old timers" include:

"When you arrive, you meet one barrier after another."

"This is a sick community."

"When I first came, all personnel (including me) were really committed to jobs and helping Indian people with health problems, but commitment finally disintegrates."

"Too many personnel lack identity with the Service Unit as a whole, their horizon may include just hospital and exclude field health activities."

"I have been told Pine Ridge is the worst place! If you can make it here, you're in."

"Provincialism of individuals becomes apparent in petty gossip and narrow points of view--they seem to have nothing more important to do."

"A person can't continue making excuses for the hospital indefinitely."

"Would it be possible to help doctors feel a part of the total group? That their functions also depend on relationships with other personnel?"

c. Record of Staff Activities

Documenting staff activities by means of the McBee Cards was underway by fiscal 1969. Some of the results are presented in the later sections on consultation and direct clinical services.

Other studies of a relatively short-term nature were carried out as the base-line study was progressing. These included a study of suicide and self-destructive behavior, a study of juvenile offense on the reservation, a study of gas and glue sniffing among the school-age population, description of native medicine and Yuwipi ceremonies, and a series of community portraits.

All were duly reported in the bimonthly Pine Ridge Research Bulletin (1967-1970).

It is sometimes difficult to be sure how, if at all, such an ambitious research program is helpful in developing mental health services. During the second year of publication of the Bulletin, the editor, Eileen Maynard, addressed herself to this issue:

> The Bulletin is now entering its second year of publication and our mailing list grows. In order to bring the list up-to-date, we recently sent out requests asking our readers to indicate if they wished to remain on the mailing list and to comment on the Bulletin. The response was most gratifying and we of the staff would like to express our thanks for all of your encouraging remarks about our publication. We only hope we can live up to your expectations in the future.
>
> From the comments we now know all of the myriad uses of our articles. Some are using the statistics in program planning and to provide ammunition to secure grants. Others find the ideas and statistics useful for comparative purposes in carrying out research on other Indian tribes. Some government

workers and educators have said that the Bulletin provides them with insights into Indian behavior and helps them in their relations with Indians. Several university professors are using the information in teaching courses on Indians. For many, the utility of the Bulletin is in providing a better understanding of Indians and their problems.

3. Medical Services and the Mental Health Program

Close early relationships were established with the Service Unit medical programs. The model used here was somewhat different from that in other areas. For example, in the Portland Area the alliance with medical care facilities was adopted because it offered a point of entree for the mental health program through the vehicle of an already established and well-accepted program (see Portland Area chapter). In Pine Ridge, however, the decision had apparently been made that the mental health program could provide one of its most effective services by means of consultation to the medical facilities, and they stressed the need for integration of services, rather than autonomy for the mental health program.

The mental health team attached themselves to the fifty-eight bed Service Unit Hospital which provided inpatient care as well as maintaining general medical and surgical outpatient clinics. The Social Worker provided by the Social Service Branch was thus integrated into the Mental Health Program. Members of the Mental Health staff also allied themselves with the Field Health Unit which was responsible for the preventive aspects of the Service Unit program. Field Health staff maintained community clinics in outlying places and were also involved with prenatal and well-child services, school health, sanitation and tuberculosis control.

Early on, the mental health team was concerned with what it conceptualized as communication problems between Service Unit staff and their Indian clientele. They tended to attribute such findings as a high proportion of patients leaving the hospital against medical advice (AMA) or without leave (AWOL) as well as the frequent failure to take prescribed medicines regularly, as communications problems. As a means of gathering useful data, the mental health team arranged for all complaints received by Service Unit staff to be recorded and routed to the mental health team for study.

Five major consultative thrusts evolved in working with the health care system. They are briefly described under their respective headings: (a) Hospital, (b) Field Health Unit, (c) Sioux Sanitarium, (d) Orientation Committee, and (e) Wanblee Health Center which is discussed under community development.

a. Hospital

Maurice Miller, psychiatric social worker with the program from its inception in 1966, was joined by Paul Stuart. Mr. Stuart worked under Mr. Miller's supervision in the Service Unit Hospital, responding to referrals from the Service Unit staff.

Frances Locke, recruited as a Social Service aide under the combined OEO-Mental Health Program already described, was assigned to the hospital to work under Mr. Stuart's supervision. The intent was for the Social Work Aide to interview patients, to translate, to arrange for nursing home placements and to bridge the gap between the patient and his home community.

In 1968 the number of Social Workers was increased by the addition of Mr. James Wills. Ms. Locke resigned and was replaced by Belva Clemens who resigned after three months of service.

A later occupant of the position, Mrs. Frances Afraid of Hawk, describes her activities in a memo of 1969:

TYPICAL ACTIVITY OF INDIGENOUS CASEWORK AIDE

Mrs. Frances Afraid of Hawk, the Social Work Aide at the Hospital, began working with the social worker in January 1967, and is continuing her work under the direction of the Social Worker, Mr. Don Ostendorf. Speaking Lakota, she works sensitively with the Indian people who require many kinds of help and describes here helping an elderly couple move to a nursing home. The goal was to help the couple develop a positive feeling and attitude about entering a nursing home.

There is a residence for elderly people at Pine Ridge, Felix Cohen Memorial Home. However, it is not possible for patients to receive nursing care outside the hospital on the reservation at this time. Even in the Cohen Home residents feel isolated from family and friends. Some voice the feeling that family and friends have forgotten them. For this reason several residents return to their home communities during warm weather. Since many fear to enter Cohen Home, which is on the reservation, many people needing convalescent care have much fear of entering a nursing home off the reservation. Mrs. Afraid of Hawk's case report follows:

> During the month of May, I had the opportunity of touring two nursing homes with patients who had been in the hospital, helping them accept admission to a nursing home and separation from relatives and friends. I was assigned this couple in April 1968, and have continued with them throughout the year.
>
> Mr. and Mrs. Jones (a fictitious name) are an elderly couple who live on the reservation. Their home is in fairly good shape except that no cleaning or straightening has ever been done.
>
> Mrs. Jones is anemic and senile, so that she has little energy and forgets to cook and attend to the household chores. She has often been seen wandering around outside her home picking up different articles off the ground. I have had many complaints from her neighbors and others in the community of her inappropriate behavior. Mr. Jones is pretty alert, but has a hearing problem and poor vision.

> Many home visits were made by me and the Community Health Aides to discuss the possibility of nursing home care. Finally, Mr. and Mrs. Jones thought it would be a good idea to visit a nursing home. They were a little hesitant, of course, as they had their fears and doubts about what a nursing home would be like. Fortunately there were several Lakota-speaking indigenous aides on the staff at the home who were helpful to them in making the decision, and will also be in the possibility of future referrals.
>
> A week after our tour of the nursing home Mrs. Jones decided it would be the best place for her in recognition of her own unmet needs. With permission, the Community Health Aide and I bathed and deloused her at the hospital prior to her admission to the home. Mr. Jones is presently preparing himself to go to the nursing home in the near future.
>
> I expect to be able to help other Indian people in need of convalescent care in the same way, whether referred by the physicians, nurses, or others in the community.

The psychiatrist and mental health nurse attempted to set up a series of consultations with other hospital personnel--physicians on the pediatric, medical and surgical services, and the nursing staff. Apparently, the most responsive group was the pediatric service, and the practice of attending pediatric rounds was instituted on a regular basis. An attempt to develop in-service training programs for nursing personnel was not successful because of a lack of personnel time, followed by the prolonged absence of Ms. Gill, the MH team's nurse, after a serious automobile accident. During fiscal year 1969 the records and staff of the hospital Social Service were merged with those of the Community Mental Health Program.

b. Field Health Unit

The staff was responsive to referrals and requests for consultation from the Service Unit personnel. They were also involved with a Service Unit committee to study plans for improved care of diabetic patients.

In 1966 an in-service education program was held for all Service Unit staff in order to sensitize them to Sioux culture and communication problems. This was funded as a Technical Assistance Project through the Mental Health Section of the State Health Department and the Kansas City Regional Office of HEW.

c. Sioux Sanitarium

Under the leadership of Mr. Stuart, the mental health staff undertook major responsibility for the development of a program to insure continuity of care for tuberculosis patients from Pine Ridge sent for treatment to the United States P.H.S. Indian Hospital in Rapid City. This program interest was stimulated by continuing reports about patients who left the hospital AMA or AWOL or who failed to take their anti-tuberculosis medications as instructed.

There were two major goals of this program: (i) To increase understanding about tuberculosis both among patients and among their families and (ii) To break down feelings of loneliness at the Sioux Sanitarium. A community education project was launched, and Mr. Stuart acted as a link between the patient and his family, bringing messages each way and encouraging people to use the tape recorder as a means of communication.

Miss Gill began to go with Mr. Stuart on his weekly trips in order to carry out an in-service program for nursing personnel at the Sioux Sanitarium. This program continued for several years until it was dropped in fiscal 1969, probably because there were no longer large numbers of TB patients to be hospitalized in Rapid City.

d. Service-wide Orientation

A Service Unit-wide Orientation Committee for incoming IHS personnel was formed by Dr. Michael Ogden, SUD. Members of the committee included mental health personnel who had demonstrated their concern for problems of incoming IHS staff by means of the study described earlier. Input from the mental health team to this program included an informal course on traditional Sioux culture. The course was attended by local teachers as well as IHS staff.*

4. Consultation and Community Development

In keeping with their announced set of priorities, the mental health team was active in setting up programs involving the school systems. Interfacing was developed with a variety of other community agencies as the opportunities presented themselves. For the sake of clarity, these are presented under different topical headings even though chronologically, as well as in other ways, there is a good deal of overlap between the programs.

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* This project has developed into a regular part of the curriculum of the local community college and is taught by IHS staff.

a. School Project

Late in 1965, a consortium of agencies including BIA, Law and Order, State Welfare, PHS Health Education Branch, local ministers and the mental health team met to organize a project for school children around the theme of Planning for Family and Community Living. The attitude survey described earlier in this report had been done as one of the preliminary steps in planning this program and its results were used by the consortium.

In the initial stages of the program, all Oglala High School students were divided by religion and by sex, and the curricula offered were varied accordingly. The Mental Health Nurse met with the girls and the Psychiatric Social Worker with the boys.

This in turn generated a number of other school-related projects, including:

i) In-service training was offered to instructional aides as well as the discussion groups with the students themselves.

ii) Evaluation of individual cases was offered in the Oglala Community School dormitory.

iii) Workshops in cognitive development were offered. These were attended by BIA teachers, as well as instructors from parochial schools, unified schools, the Shannon County schools, and Headstart and Parent and Child Centers.

iv) A "Growing Up" Program: This was based on teaching fundamental behavioral science principles to elementary school pupils as developed by Ralph Ojemann and his associates at the University of Iowa. The inception of the program is described in Progress Report of mid-1970.

> Oglala Community School and Title I (via the Oglala Sioux Tribe) have been notified that their grant request (for funds to introduce at Elementary and Middle Schools, the materials by Ralph Ojemann and Associates) has been approved. This "Growing Up Program" will require an Indian assistant for each classroom, grades one through three. The Mental Health nurse consultant will be involved as a consultant and educator in working with personnel through the fifth grade and the guidance counselor at the middle school, sixth through eighth. Meetings about the introduction of the "Growing Up Program" have been held through June for personnel in the girl's dormitory and will continue through July. Seminars are planned July and August for teachers to discuss the philosophy behind this approach with the mental health nurse consultant. In addition, the mental health nurse consultant will work with the Indian classroom assistants, alerting them to focusing their observation of student behavior, methods for making anecdotal notes, how to write more extensive reports, etc. Both these women and men work closely with the teachers in the classroom to which they are assigned.

v) A referral program for underachievers was introduced into the BIA schools. During the first three months of the program, a total of 122 referrals was received.

vi) The mental health team, responding to the call for services, evidenced by referrals for underachievement as well as to other problems, stimulated the formation of a guidance committee. This committee was composed of guidance department personnel, principles and the mental health team itself. The function of the committee was to screen cases referred by individual teachers, and to conduct ongoing studies in relation to instruction, guidance, and mental health in the schools.

b. Big Brothers Project

The preliminary studies carried out for the Baseline Study indicated that a great many boys on reservations were growing up without fathers or other readily available adult male models. By fiscal 1967, the mental health team, in conjunction with the Pine Ridge Jaycees, had established Big Brothers Programs in four different communities.

c. Welfare Department

Consultation was initiated to the County Welfare Department with particular emphasis on the problems of ADC mothers. Joint conferences with Welfare on a montly basis was part of this program.

d. OEO

In 1967 discussions began about a Community Service Center program which would be modeled on the idea of Neighborhood Service Centers in larger cities. OEO assumed a major role in setting up the centers, and Mental Health staff were assigned to specific communities -- in particular, Manderson, Porcupine and Kyle.

Paul Stuart moved out from his hospital position to have a major responsibility for the three community programs. The centers were staffed mainly by VISTA volunteers, and since they served as the location for most Parent-Child Center activities (described in the next section), one assumes that there was considerable overlap in function as well.

e. Parent and Child Centers

The OEO offered Pine Ridge the opportunity to apply for funds to establish Parent and Child Centers. The model, developed elsewhere, was for a center which would serve the needs of disadvantaged families who had one or more children under the age of three.

The Community Board applied for a $10,000.00 planning grant for the communities of Kyle and Manderson, with Mr. Miller of the mental health team a temporary director.

OEO decided to add Porcupine to the communities to be included in the grant and called for two members from each of the three communities to serve on theplanning committee. The committee, as eventually constituted, also included representatives of BIA Welfare and State Welfare as well as Mr. Miller who acted in the dual role of PHS and Mental Health representative.

Mr. Wills and Mr. Stuart of the mental health team also attended these meetings and offered consultation.

The program was implemented in fiscal 1969 with an emphasis on activities for parents. This included carpentry classes for men and arts and crafts for women.

f. The Wanblee Project

During fiscal 1967, the SUD offered the people of Wanblee a choice between a health center in their community or free daily bus service to Pine Ridge for medical attention, plus twenty-four hour a day ambulance service. The eventual decision was for a new health service but, according to a report of February 1967, the process by which a decision was reached made the outcome neither clear-cut nor definitely representative. Since this is an interesting and rare opportunity to glimpse a community in action, the note is quoted below

> ### Wanblee Community Meetings.
>
> Some members of the Mental Helath Team recently had the unique opportunity to witness and be involved in a community's decision about how to meet their own health needs. The Acting Service Unit Director offered to the people of Wanblee the choice of having:
>
> 1. A free bus transportation service which would begin within months, would operate daily and would transport people back and forth to Pine Ridge, plus a 24-hour ambulance service or
>
> 2. A Health Center already scheduled for construction in late 1968 or early 1969.
>
> On 2/03/67 a meeting was held and the 23 community people in attendance voted unanimously for the transportation service. It was decided to hold another meeting the next day, however, so that more people might be involved and they might have more time to consider their decision. At the second meeting, with about 44 present, the vote was 21 for the health center and 19 for the transportation. This vote was accepted by Service Unit Personnel as final and official. Twenty-three members of the community met again the next day and voted unanimously for the health center.
>
> A number of interesting observations were made during these meetings:
>
> 1. It was interesting to note that following the official votes some of the people angrily expressed their views in favor of the transportation service, but these people had not spoken up at all during the meetings.
> 2. Two individuals were obviously influential in the decision. They were a teacher at the local Bureau of Indian Affairs School and a local volunteer Health Committee Worker who had long worked to get the Health Center in Wanblee.
> 3. The matter of a secret ballot was very important as when a hand vote was taken before the secret ballot many watched to see how influential members voted before they themselves voted.

4. Insufficient time was given to the community to organize and think logically about the decision and this should be kept in mind in offering communities decisions like this in the future.
5. We believe more opportunities to make important decisions should be given to the Indian people. To do this effectively however:

    1. enough time needs to be given to consider the decision,
    2. the decision or choice should be about real and immediate needs perceived by the people,
    3. this kind of decision making needs to be offered consistently at every opportunity,
    4. and the community people must be assured that local agency people have the authority to follow through on the decisions made.

The Health Center actually opened during fiscal 1968. A Service Unit Health Board was formed, comprised of four Tribal Council members and four members at large nominated by the Tribal Council. A Community Mental Health consultation program continued with Wanblee until fiscal 1971, when a feull-time MH Worker position was assigned to the program. It seems from a report of mid-1970 that the scope of activities extended beyond mental health or even general health considerations.

> During this past quarter Mr. Robert Church, a psychiatric social worker changed his duty station from the Community Mental Health Program in Pine Ridge to the Wanblee community. This assignment change represents an attempt by the Community Mental Health Program to move into community consultation on a full time basis. Mr. Church's task in the Wanblee community will be to assist the leaders of the community in planning programs to meet the felt needs of the community. As community consultant to Wanblee Mr. Church meets regularly with the following individuals and groups:
>
> 1. The district chairman and district council.
> 2. The principal and teachers of the Wanblee Day School.
> 3. The tribal policeman
> 4. Local clergy
> 5. The community health board
> 6. The tribal representatives

Mr. Church also attempts to facilitate communication between local leaders and resource people in other government agencies.

Currently Mr. Church is aiding the community in its efforts toward economic development. He is attempting to facilitate communication between community residents and resource people in the Small Business Administration and EDA. It is hoped that a small leather goods factory will be begun in Wanblee with the help of these agencies. Mr. Church is also working closely with Mr. Elijah Whirlwind Horse, the principal of Wanblee Day School in developing a special education class for children with educational handicaps.

D. Direct Clinical Services, Carl Mindell, M.D.

1. Relationships with Research Staff

It has become apparent in the overview and selected highlights of the research, baseline, and community activities, that the availability of a large budget for these activities provides a wealth of valuable experience and information not ordinarily available. In most mental health programs, both within IHS and in Community Mental Health Centers and local service-oriented clinics, the demand for services is slow in the beginning, allowing leisure for planning and research, but it soon increases geometrically to the point that all staff time is taken up with service delivery and administration. Research time, even evaluations of one's own programs, is hastily accomplished via dedicated persons on overtime, or through interrupting services occasionally for staff purposes. In general it is considered a luxury that cannot be afforded when the primary raison d'etre is service delivery. The Pine Ridge program was fortunate during its early years to have the budget that provided for both, and to have the direction of the anthropologist Eileen Maynard whose full attention could be devoted to the research aspects, while herself remaining sensitive to clinical and service issues.

This does not imply, however, that services of direct clinical nature were omitted from the staff planning and activities. Carl Mindell, M.D. who joined the staff in 1969, was a well-trained child psychiatrist, and under his parallel direction clinical services were developed. He too was a fortunate match, with interests in understanding the community in order that services offered would be appropriately designed and well received. His efforts to understand the Oglala Sioux included living for a time with a local Indian family, an occasion which offered some wry amusements as well as learning experiences. Reflected in informal notes from talking later with the Pine Ridge community, are comments about the equal need of the family and community to understand the psychiatrist and the mental health program. Quips about the fact that after he had spent time in the family they might all be shipped off to the state hospital show both humorous acceptance and veiled hostility and misunderstanding.

The tripartite organization of social life on the reservation, with parallel activities and interests of Full Blood, Mixed Blood, and non-Indian residents made many barriers to informal interaction. Certainly the location of Pine Ridge hospital on a high hill, like a fortress, and the fact that many, if not most, of the government employees lived and worked and played within their own "compound" and society, made such efforts novel experiences. It is certain that Dr. Mindell's efforts in this direction, his highly active participation in local programs of the service clubs, school organizations, and his availability as a speaker and consultant, fostered the integration of the research and service delivery components of the Pine Ridge program as it was originally conceived.

2. Fiscal 1967 Clinical Statistics Report

By the fiscal year 1967 a well-established pattern of direct services was extant, and a summary of that year's work is given in the annual report of the program as follows:

Number of Patients Seen by Psychiatrist

Age	Number	Percent
0-10	19	13.7
11-15	24	17.3
16-20	13	9.4
21-25	17	12.3
26-30	19	13.7
31-35	15	10.8
36-40	14	10.1
41-45	5	3.6
46-50	4	2.9
over 50	8	5.8
TOTAL:	138	100.6

It is of interest that 87.7 percent of the patients seen were 40 or under. As will be seen later a high percentage of older people seen have problems related to acute brain syndrome secondary to alcohol.

Sex of Patients Seen by Psychiatrist

Sex	Number	Percent
Men	61	44.2
Women	77	55.7
TOTAL:	138	

DIAGNOSES*

	Number	Percent
Neurosis	62	43.6
Psychosis (excluding brain syndromes)	13	9.1
Brain Syndromes, acute and chronic	22	15.4
Character disorders	12	8.4
Childhood Behavioral disorders	10	7
Childhood Developmental deviations	8	5.6
Mental retardation	6	4.2
Normal, that is no psychiatric diagnosis	2	1.4
No psychiatric diagnosis (not enough information)	7	4.9
TOTAL:	142*	

*The total here add up to more than 138 because in several cases it was impossible to give more weight to one diagnosis than to another.

The largest number of neurotic problems was related to depression. The high percentage of brain syndromes is of interest.

CHILDREN*

Age Range of Children

Age	Number	Percent of the total number of children
0-5	4	7.7
6-10	13	25
11-15	24	46
16-20	11	21.1
TOTAL	52	

*The 52 children seen were 37.6 percent of the total

Blood Quantum

	Number	Percent of the total number of children
Full Bloods	13	25.8

Children Living with Guardians

	Number	Percent of the total number of children
Both parents	20	38.4
One parent	7	13.5
A Foster parent or other relative	10	19.2
Grandparents	9	17.3
No one acting as guardian	6	11.5

PSYCHOSIS*

	Number	Percent
Acute Brain Syndrome	14	52 of all psychotics
delirium tremens	12	
alcoholic hallucinosis	2	
Schizophrenia Diagnosis here included acute and chronic undifferentiated paranoid schizo-affective and residual type	7	26
Borderline State	4	15
Psychotic Depression	1	
Hysterical psychosis	1	
TOTAL:	27*	

*This total represents 19.5 percent of the total seen.

Rather than obscure the differences in age related to the organic and functional psychoses age data is given separately.

Acute Brain Syndrome and Functional Psychoses By Age

Age	Acute Brain Syndrome	Functional Psychosis
0-10	0	0
11-20	0	4
21-30	3	5
31-40	6	3
41-50	2	0
over 51	3	1

It is striking that the most common reason for seeing an older person is an acute brain syndrome. The sex ratio for acute brain syndrome is 10 men to 4 women.

3. Analysis of Suicide Attempts for Fiscal 1967

This same report gives detailed analysis of the suicide attempts and services rendered for the fiscal year 1967 which is reproduced here in full since it shows the baselines from which later work was extrapolated, and because this topic is of keen interest to all IHS mental health programs.

Suicide statistics:

The following are the Community Mental Health Program statistics regarding suicide and suicide attempts during the year July 1966 through June 1967. There were no successful suicides reported as such but we have no idea how often cars, for example, were used for suicide. Twenty-five persons who had made suicide attempts or threats were seen. Included here are five threats judged to be significant. Using a population base of 10,000 this gives an attempted suicide rate of about 250 people per 100,000 or somewhat more than twice the suicide attempt rate reported by Schneidman and Farberow in Los Angeles. The following figures then relate to suicide attempts.

Age

	Percent
Under 40	96
Under 29	68
Under 19	36

Sex

	Percent
Men	20
Women	80

This more or less corresponds with the national statistics.

Marital Status

	Percent
Married	36
Single	60

These figures probably reflect the young age of many of the attempters.

Blood Quantum

	Percent
Full Blood	37
Mixed Blood	62

This approximates the proportion of Full Bloods on the reservation.

Severity

	Percent
Mild	68
Moderate	24
Severe	8

Severity was determined on a scale of mild, moderate, or severe. The estimation of severity was made by a scale which included weighting the method used, the intent of the suicide attempt and the way that the person was found. There was no significant relationship between severity and sex, or severity and age.

Method

	Number	Percent
Overdose	14	53
Hanging	2	7
Wrist cutting	5	19
Thoughts	5	19

Previous Contacts with Public Health Service Hospital*

	Number	Percent
One day previous to attempt	5	19
2-7 days previous to attempt	4	15

*These figures are based on 26 attempts. Therefore 34 percent of people who made suicide attempts contacted the hospital within one week of the attempt.

Previous Attempts

	Number	Percent
History of previous suicide attempts	7	31
No history of previous suicide attempts	15	68

Most Common Precipitating Stresses

	Number	Percent
Felt rejection by important person	13	52
Interference in the family by relatives moving in	4	16
Psychotic	3	12
Other	5	20

Diagnoses

	Percent
Neurotic	52*
Psychosis	16
Character Disorder	16
Not enough information to make a psychiatric diagnosis	16

As in other studies diagnoses related to suicide attempts ranged throughout all possibilities.
*Depressive reactions accounted for a total of 40 percent of the entire sample.

Intent of the Suicide Attempt

	Number	Percent
To change an important relationship	13	52
To die	4	16
To get out of a situation	5	20
Other	3	12

Dynamics:

The most frequent dynamics involved the disruption of a close hostile dependent or symbiotic relationship which resulted in extreme feelings of helplessness and anger which is turned inwards.

On the Pine Ridge Indian Reservation the model patient who attempts suicide is most likely to have the following characteristics. It will be a young woman under the age of 29 and quite likely under the age of 19, who is single and a mixed blood. The suicide attempt is mild and most likely accomplished by taking an overdose of medication. There is one chance in three that the patient has made a previous suicide attempt, and also one chance in three that the patient has made some cry for help within one week of the attempt. Diagnostically the patient will have neurosis. The attempt will probably be precipitated by a felt rejection by an important meaningful person to the patient who probably was involved in an intense hostile dependent or symbiotic relationship with this other person. The suicide attempt is then used usually to reestablish the old relationship.

4. Clinical Services within the Hospital Framework

These statistical summaries represent a high level of activity and indicate that much coordination with the medical services of Pine Ridge Hospital had been accomplished. Dr. Mindell as a psychiatrist was especially seen as someone with whom the medical and nursing staffs could relate, and had the assistance of the social workers assigned by the Social Service Branch as well as of a social work aide in carrying the clinical load.

Work with the hospital staff also included developing a play recreation program for children hospitalized in the pediatric service, utilizing a visitor, Susan Pokrass, a special education teacher from Albert Einstein College of Medicine in New York City. Under the supervision of the medical social worker, three volunteers (a registered nurse and two Neighborhood Youth Corps members) organized play, aided with studies, and ate with the children. These activities greatly facilitated the adjustment of the children and also allowed early case finding and referral for special services, especially evaluations by the mental health staff. Although this program was outstanding while volunteers were available, in later years it disappeared for lack of budget and staff to maintain it.

5. Other Activities of the Psychiatrist

While an initial primary source of referrals was from the Pine Ridge Hospital staff, the borad base of the work of the total mental health unit, and the involvement of all of its staff in community consultation activities created acceptance, and an increasing number of self-referrals and non-medically related referrals occurred as Pine Ridge developed its program.

Dr. Mindell's activities included many talks to varied audiences, and his scholarly training enabled him to prepare these and contributions to the Research Bulletins in a manner comparable to that used in general psychiatric literature. An example is his discussion of alcoholism presented at the adjacent Rosebud Reservation to a Tribal Workshop in October of 1967. In this discussion, entitled *Clinical Aspects of the Use of Alcohol Among the Oglala Sioux*, he suggests a typology of persons with alcohol problems:

First, the Chronic Alcoholic, usually referred by the jails, who has been drinking a long time, steadily, and although he may have wanted to quit at times, cannot manage it. This type of alcoholic has no steady employment, often no family ties, and no fixed abode. His drinking is part of a general deterioration in many areas of living.

The second type is described as a Binge Drinker or 'reactive alcoholic'. Persons of this type usually can hold jobs for long periods, but jeopardize them with a prolonged drinking binge which is reactive to personal loss, rejection, separation, and the like. This group is far healthier socially and physically than the Chronic Alcoholic, having family and friends, vocation and other ties to the community. They are nevertheless addicted to alcohol as a way of dealing with problems and depressions.

The third type is described as drinking heavily but not having to do so. Dr. Mindell feels this is the largest group in the population, and represents the weekend parties and recreation for a large segment of the population. There are usually arrangements made for the care of children, and jobs are not jeopardized.

The fourth type is not necessarily a drinker, but one who is affected by someone else in the family or close circle of associates who does drink. These individuals may be afraid of their own impulses, and see drinking as losing all control. They cannot make distinctions between the other three types, and therefore are often socially ostracized. This group also includes the children of alcoholics, and the grandchildren, or other relatives of those for whom alcohol has become an addictive problem. They are caught between learned social values against alcohol and the patterns of turning to alcohol learned from observation and interaction with their families.

In this article Dr. Mindell also presents the useful functions of alcohol in the social patterning and adjustments faced by contemporary Indian populations as well as the obstacles to developing treatment programs. Some of these obstacles are located in the myths about alcoholism, some in the attitudes the "helpers" bring to the situation, and some in the structure of the community itself. Overall the paper presents a refreshing point of view, and one which should have had a wide audience throughout the IHS and other Indian agencies. That it is not better known may be due to the fact that, generally speaking, programs of alcohol rehabilitation began to be developed shortly thereafter under the auspices of other agencies such as NIAAA and tribal OEO programs, and IHS staff saw themselves in consultant and auxilliary roles rather than major suppliers of treatment services.

Other papers developed by Dr. Mindell on suicide, juvenile delinquency and related topics have already been summarized or are reflected in the integrated work of the research and service delivery arms of the Pine Ridge Mental Health Program.

E. Involvement of non-psychiatric Specialists at Pine Ridge

It has already become clear that non-psychiatric specialists were closely involved with the development of the Pine Ridge Mental Health Program. The baseline studies and Research Bulletins were under the general direction of Eileen Maynard, an anthropologist who remained with the program for nearly five years. Eleanor Gill, a public health nurse, was also quite active in the community and field work, and the only sociologist assigned to the program, Philip May, M.A., was oriented toward social psychology and statistical matters more than to clinical psychology practice. Administrative and research staff had generally shorter tours of duty, with the exception of Gayla Twiss who began in 1968-69 as a research aide, acquired clinical training, and has since become the director of the program. Her early work has already been noted in the publication That These People May Live.

1. Visitors and Volunteers

Gilbert Voyott, a protege of Piaget, appeared on the Pine Ridge Reservation about 1968 to do a study of Sioux children which would test the generalizability of Piagetian developmental stages, especially those related to cognitive development. An unusually perceptive man, Dr. Voyott believed that as a researcher he should offer something of equal value to the community providing him with data. He spent many hours in consultation with the Mental Health staff of IHS, especially those concerned with school consultation. Gayla Twiss was especially able to work out with Dr. Voyott adaptations of his instruments which would yield diagnostic information on children's learning abilities and disabilities for teachers, and develop remedial plans on a prescriptive individualized basis.

Dr. Voyott arranged for Ms. Twiss to spend time in New York City securing basic skills in psychological testing through the graduate schools at Columbia University and elsewhere to increase her proficiency in this specialty. He has returned almost annually to Pine Ridge to continue his consultative role and to work with the teachers and IHS staff. Unfortunately, in a recent move of Area Office quarters his reports and research materials have been lost, and are not available for documentation here. However, he is in the process of a major publication in book form which should become available in 1975, and which will include much of the relevant information developed at Pine Ridge in a national and inter-national perspective.

Like Dr. Voyott and Miss Pokrass, there were many visitors to Pine Ridge during the early phases of the program. Dr. Edward Greenwood of the Menninger Foundation was a frequent and thoughtful visitor over the years. Dr. Karl Menninger also visited and made valuable talks to the staff and community. Virginia Satir conducted a workshop on her particular variety of conjoint family therapy. A complete roster of these distinguished guests and their contributions has not been retrieved, but it would be studded with stars from the cross-disciplinary mental health world at large. Most of these made some contribution in exchange for their own learning and growth. Some were aided by research grants and travel assistance from a wide variety of sources including HEW, AAIA, and university sabbaticals.

Some of this interest was merely a continuation of long established interest in the Oglala Sioux as a people and the general accessability that has already been noted. Some of it was kindled by information disseminated through the Research Bulletins, and by recognition of the imaginative planning integrated into the model program. Of all the early IHS mental health programs this was the most accessable, and the very emphasis on research made it possible to discuss with visitors the kinds of questions which often harrass a small, overburdened staff engaged in a service delivery process that seems to have all the characteristics of the stone pushed by Sisyphus. These varied inputs, and the perspective from a world view off the reservation that they brought to the staff, have enriched its planning and development in many subtle and sometimes unrecognized ways.

2. Paraprofessional Staff

The use of paraprofessional staff was a much discussed aspect of the Pine Ridge program in its early phases. The need for interpreters was in some ways not as crucial as on the Navajo Reservation, since, as has been noted, the majority of the population was either bilingual or spoke mainly English. However, the comfort of being able to use a native first language in times of stress, and the possibility that persons with emotional disturbances could better communicate in Oglala than in English the subtleties and intimacies involved in their situations, all made some emphasis on local indigenous staff essential. Particularly as field research and mental health work progressed these needs were more and more evident.

The Social Work Aide Program had already been initiated in the Area as a way of developing local Indian people in an entry level career in social work which could place them appropriately on the career ladder, and could provide professional training through a close tutorial supervision combined with local academic offerings. This program is discussed also in the Portland Area chapter.

In addition to social work aides, research and clerical work positions offered another early entry point for local Sioux personnel. As research aides and assistants they were able to acquire valuable skills, without being immediately plunged into the complexities of clinical service delivery. This also offered the staff of non-Indian professionals opportunities to learn the realities of working with bright capable individuals who had not had the benefit of mainstream educational grooming.

It was not until the field clinic at Wanblee became established that Mental Health Workers as conceived on the Navajo and in other later-developing IHS mental health programs began to be utilized. This may have been due to the unfamiliarity of the professional staff with the paraprofessional experiences in and out of IHS across the country. In other instances it may have been due to the heavy weighting of the clinical service staff with social workers, who depended on the Social Work Aide model. And finally, the heavy investment in the research base made all the non-Indian professional staff more secure in their understanding of the Oglala culture and their relationships with many agencies and socio-political units of the reservation. The need for linguistic cultural translators was not as keenly felt at first by clinical staff as in other Areas, and on other reservations in the Aberdeen Area. This is not to apologize for the few mental health worker positions. The foundations for such a program were laid, but its early development was not as dramatic as in many programs where the recruiting and training of paraprofessional staff was a major initial activity.

3. Social Work Supports

The Social Services Branch supplied at least one medical social worker at all times to the Pine Ridge Hospital. This individual, in addition to a social work rounds, was always a liaison between the mental health staff and the hospital itself, and functioned as a part of the mental health program overall design. In addition, social workers were added to the mental health staff with the express purpose in mind of their performing clinical and community services. This has been compatable with the development of mental health services throughout the Area in later years, since as has been noted, the early roots of such activities lay within the Social Services Branch of the Aberdeen Area.

F. Change of Command: Donald Burnap, M.D. 1970-71

In the beginning Dr. Mindell had assumed he would be making his career within IHS and there was an expectation that he would be several years at Pine Ridge. However, personal needs asserted themselves, and after completing his first tour of two years he left both Pine Ridge and IHS, first for additional study and finally to assume administrative duties with the Department of Mental Health in Albany, New York, where he is in charge of Children's Services. He continues to be available as an occasional consultant, and often serves in this way through the American Association of Indian Affairs. He is also a member of the American Academy of Pediatrics Task Force on American Indians. In these ways, as well as in his influence on the original staff and later activities of the Pine Ridge staff, his influence persists.

Dr. Mindell's departure did not result in immediate replacement, but in 1970 when Donald Burnap, M.D., became available at the conclusion of his residency, he was assigned to the Aberdeen Area and Pine Ridge. He joined a staff which had already begun to loosen around the gap left by Dr. Mindell, and without an opportunity to be inducted by one of his own profession into the roles of the psychiatrist as they had previously been established. He remained only 6-8 months at Pine Ridge before moving his base to the Area office in Aberdeen as Chief of Mental Health Programs. It is in many ways unfortunate that this move made him the representative and carrier of the Pine Ridge model to the rest of the Area before he had had a chance to fully experience it, or become knowledgeable of all its complexities.

It is probably appropriate at this point to interrupt the narrative of the development of the Pine Ridge Mental Health Program and return to the Area-wide perspective which was described in the earlier sections of this report. Later developments and current aspects of the Pine Ridge Program will be included in the summary of each Service Unit as it presented itself in 1973-74.

IV. EXPANSION FROM AREA OFFICE TO OTHER SERVICE UNITS

A. Donald Burnap, M.D. 1971-72

One of the first tasks for Dr. Burnap as Area Mental Health Chief was to tour all of the Service Units, developing and renewing the consultation contacts pioneered by John Bjork, MSW, who had left for a new assignment in Oklahoma. He found himself defining the roles, functions and advantages of IHS mental health staff and consultants rather than contract services to the local physicians. He spoke with tribal advisory health boards, and the other agencies serving the reservation population, as well as Service Unit staffs.

He also found a wide variety of receptions, and describes these rather vividly in undocumented conversations. In several instances the health advisory boards, having been used to utilizing the off reservation and non-IHS consultants, were ready to utilize and anxious to have additional staff at the IHS facility who would extend and carry out the functions Dr. Burnap described. In other reservation settings, the local problems seemed to have quite different focii, and there were suggestions that if IHS wanted to be bountiful it could provide the equivalent of the salaries and consultation monies for the improvement of local roads! In at least one instance the local political power factions were suspicious of the possible paternalism and 'colonialism' involved. The Dakotas may seem geographically remote but they are not out of touch with the "mainstream". There are many examples of tribal groups having learned some of the modern radical rhetoric. This may reflect contact with some of the more active youth movements that were sweeping the campusses of the nation, heightened by the voices of other minority groups in urban settings.

B. Consultation Model

Dr. Burnap's model for consultation was based on that of Gerald Caplan, among others, and was an extension of techniques of psychotherapy to the agency staffs, particularly administrators of agencies. He therefore initiated the training of the mental health paraprofessionals in what he hoped were a series of graded steps from the providing of concrete services such as transportation and referral assistance to supportive relationships and then into psychotherapy. It has been his feeling that eventually the mental health worker, after accumulating a number of years of supervised experience would be as expert a therapist as the professional. He felt that they could then begin to apply these techniques to the interagency consultations as the final step in developing skills, and being able to advance along a career ladder.

C. Suicide Rates--Gestures and Completed 1969-1973

When Dr. Burnap was at the Area office level in 1972 he became interested in the problems of Indian suicidal behavior. This topic had received considerable national attention and the Mental Health and Social Services staffs were keeping a special case register of all such events that came to their attention. The results of a review of patient records in the IHS hospitals and health centers, and reports on contract medical care were summarized for fiscal years 1969 and 1971.*

Dr. Burnap's discussion covers a number of points, some of which differ widely from the currently held views on suicide prevention strategies. They include a warning about indiscriminate use of suicide registers and publicity attendant to case finding for fear of a contagion effect, for example. In general his policy disparages efforts to utilize hotline programs and suggests that IHS staff not give attention to persons suspected of suicidal behavior. This new viewpoint tended to leave Mental Health staff conflicted between models, and tended to undermine the consultations of NIMH Suicidology Staffs who had visited Pine Ridge and held workshops for Area staff.

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* For some reason 1970 is omitted from the tables and discussion provided at this time by the Area office.

It is helpful to examine the data themselves, and therefore all of these tables are reproduced here.* One interesting trend is noted, among many, that might be discussed. Between 1969 and 71 there is a dramatic rise in suicide attempts reported at Pine Ridge (from 41 to 121). This far exceeds the usual rise that occurs in statistical reporting when casefinding becomes more accurate. The table below isolates comparable figures from Rosebud and Rapid City, the two Service Units adjacent to Pine Ridge, and sharing much of the cultural and social elements that determine the behavior of the population in an overall sense. At Rapid City and Pine Ridge there was a drop again in fiscal 72 and 73, almost

Total Number of Suicide Attempts
for Fiscal 72 and Fiscal 73
in Three Selected Service Units

Fiscal Years		69	71	72	73
Pine Ridge Hosp.	attempts	41	121	54	33
Related	discharges		52	32	35
Rapid City Hosp.	attempts	9	39	25	24
Related	discharges		32	18	28
Rosebud Hosp.	attempts	29	48	59	41
Related	discharges		30	45	36

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*See Appendix to this chapter.

to the previous level at Pine Ridge, and levelling off at a substantially higher rate in Rapid City.

At Rapid City almost no incidents came to attention that did not involve the hospital or clinic staff in a medical emergency in 1969, since an outreach program is difficult in an urban setting. Nevertheless, in 1972 there was an increase of 33 percent in suicide attempts reported.

It is helpful to remember that at this time Rapid City was dealing with the aftermath of a devastating flood, which had its greatest impact in numbers affected and loss of life in the Indian community of that city. Although NIMH funds for emergency mental health teams had been requested, and approved, the political issues of impounded funds delayed their arrival until mid 1973. Grief and loss reactions would be expected to be very prevalent, and it has been pointed out by Mindell and others that the suicide attempt is often a despairing effort to rectify strained personal relationships and to move otherwise apparently unyielding situations into more comfortable alignment.

It is certainly true that on the Pine Ridge Reservation, with considerable effort to locate and give assistance to the individuals involved in suicidal gestures, many more attempts are reported. This might account for the increase in cases reported between Dr. Mindell's report of 26 in 1966, but could only partially account for the increase of 80 cases by 1971.

Perhaps even more interesting is the dip in suicide discharges of about 20 percent in the Pine Ridge figures for 1972 and 73. The data is such that we cannot parcel out how much of the drop was due to preventing hospitalization by the activities of the mental health program. Dr. Burnap felt that the earlier use was a direct result of the publicity about staff availability. Since Dr. Burnap felt it was dangerous to emphasize case finding, he accounts for the drop in reported suicides and suicide attempts as a reflection of his policies and directives.

However, there is another factor to be considered in the Pine Ridge data. The fiscal year 1971-72 is the period directly preceding the explosive confrontations and the modern "siege" at Wounded Knee which received national attention. One can speculate that perhaps the rise in suicide attempts preceding this activity may have been a sensitive barometer of unbearable conditions which led to the risk-taking and open expressions of hostility in this internal tribal struggle, as well as its attack on the federal system and the external establishment. The sudden drop in suicide gestures may relate to the opportunity to externalize this pent up hostility in ways socially acceptable to at least some portion of the local population, and in ways connected with old traditional roles and warrior identities.

This is a complex issue, one which requires sensitive and careful consideration before making snap judgments about how, when and where services should be given public attention. It is to be greatly regretted that in order to expand the mental health programs into the rest of the Aberdeen Area, the research component at Pine Ridge was dismantled and the positions redistributed. Therefore, there is no systematic record of the changes during and following the Wounded Knee confrontations in 1972-73, and no IHS staff with time to observe, record, and analyze the aftermath for comparison with the baseline data.

D. Staffing Patterns for Service Units

Unlike earlier situations when Mental Health was the responsibility of a Deputy, Dr. Burnap and Ms. Elizabeth Glasow, MSW, were parallel 'Branch Chiefs' of the Mental Health and the Social Service staffs respectively.

With the exception of Pine Ridge, it was the Social Services Branch which provided the major local resources in the Service Units with whom Dr. Burnap consulted. During his tenure Area plans were devised which later have developed as patterns for the Aberdeen Area. Underlying one of these was the assumption that of all professionals who might be hired, the MSW tended to have the broadest training in both the needed fields of clinical and community skills. Therefore, in introducing mental health services, the first staff to be hired for any Service Unit was a Social Worker. In a few instances the then present Social Worker either was transferred from one payroll to the other for budget purposes, or began functioning in a joint role even before the eventual merger of the two 'Branches'. This occurred when Dr. Burnap's two year tour was completed and he left IHS service.

The second staff member added to a Service Unit, according to this pattern, was a Mental Health Worker or Mental Health Technician, who could become the paraprofessional link between the Social Worker and the community, and receive on-the-job training. After one or more Mental Health Worker positions had been filled, a second professional, either psychologist or psychiatric consultant was added as part of the staff when budget permitted, and when contract consultations seemed inadequate to meet the growing mental health program utilization.

E. Coordination in North Dakota

As this staffing plan began to be implemented in 1972, Mr. Robert Reisenberg, Social Worker on the Turtle Mountain Reservation at Bellecourt, North Dakota began coordinating training opportunities, and developing training resources for the staffs in North Dakota. He worked with the University of

North Dakota and other academic institutions to secure academic credits and background courses for the mental health workers, as well as securing training through IHS resources such as the Desert Willow Training Center, or the alcoholism counselling programs that were available. As he travelled between the Service Units he became familiar with the range of needs and skills available, and his activities supplemented those of Dr. Burnap's more clinically-oriented consultations.

F. Fusion of the Social Service Branch and Mental Health Programs

In March 1973, after Dr. Burnap had completed his tour of duty with IHS and entered private practice in Aberdeen, Mr. Reisenberg, MSW, was transferred to the Area office with a position much like that of Mr. Bjork's at an earlier period. This increased his scope of activities to include not only South Dakota, but Minnesota and Wisconsin as well. At the same time, it seemed advisable to many people at both the Area and national level to experiment with the integration of the two major programs in the Aberdeen Area, where there had been such a constant intertwining of relationships over the years. This was formally accomplished, and Ms. Glasow was named Chief of both Social Services and Mental Health Programs. Mr. Reisenberg was named Deputy Chief, and his salary derived from the Mental Health Programs budget. The staffs at all Service Units were merged, although at Pine Ridge the hospital-based Social Worker continued to perform somewhat specialized functions, linking the community-based program with the hospital.

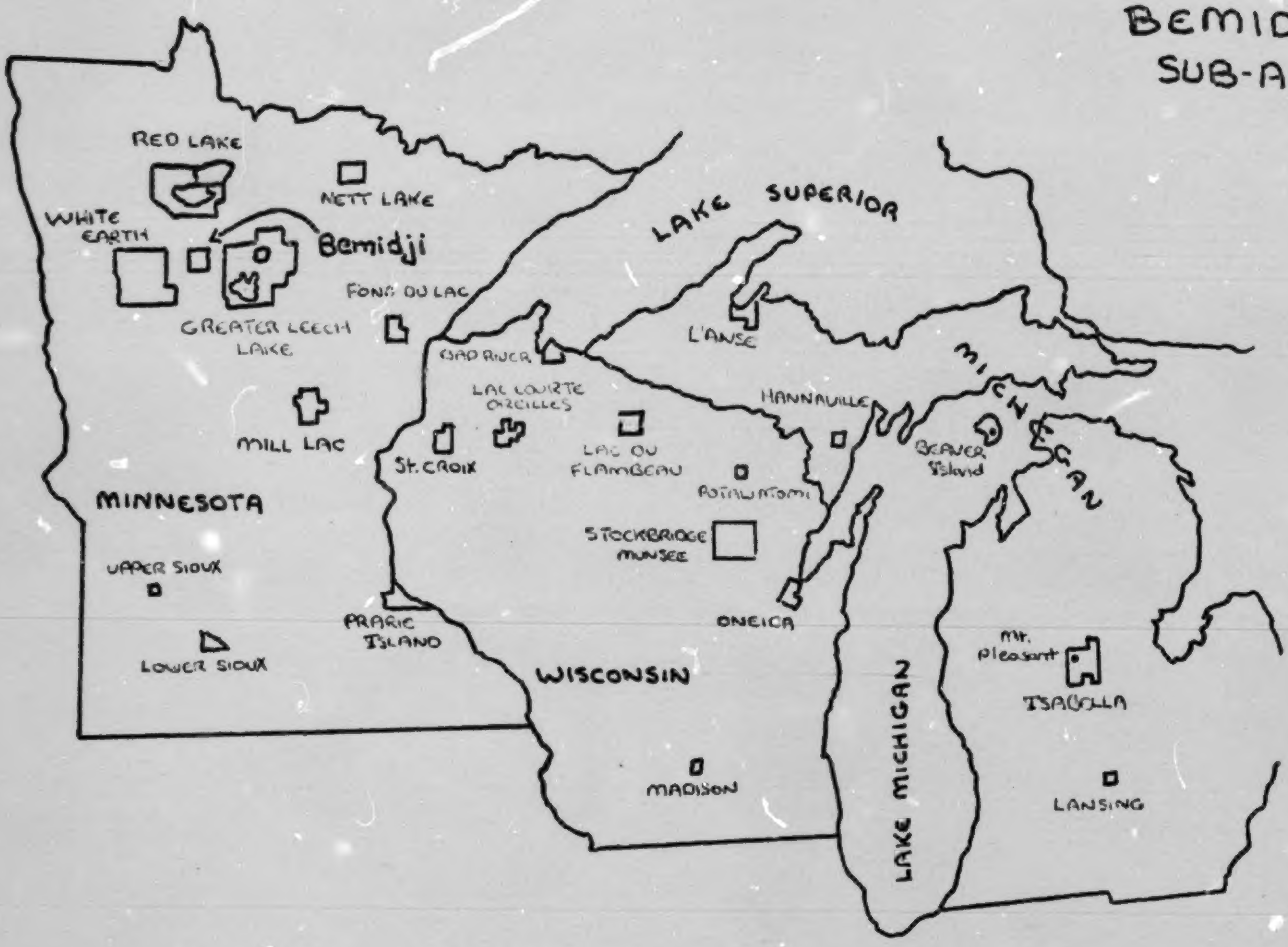
G. Area-wide Program and Staff Development

The merging of the two programs resulted in an increased emphasis on staffing the various Service Units adequately, and during 1972-73 a balance between the number of mental health staff at Pine Ridge and the total number divided among the other Service Units began to be equal. There were three psychiatrists in the program at this time, Dr. Jay Mason at Pine Ridge, Dr. M. Rogers at Rosebud, and Dr. Joseph Wakefield, who was assigned to Turtle Mountain. All had clinical and consultation responsibilities rather than administrative functions. This pattern in other Areas usually marked the beginnings of a decentralization of an Area office team which had provided its expertise by traveling to all parts of the Area. However, except for a very short period of this type of activity under Dr. Burnap, the Aberdeen Area developed in a decentralized pattern from the beginning of available funding for services to reservations other than Pine Ridge.

In some ways, there was more need in the Aberdeen Area, to centralize functions, and to develop commonalities of purpose, job descriptions, and philosophy because of the dispersed pattern of growth and the parallel functions of what had been two separate 'Branches' or program models. An Area-wide meeting for training purposes was called in the fall of 1972, and was well attended. However, on the trip home, a car accident severely injured both Dr. Mason and Ms. Gayla Twiss, key figures in the Pine Ridge program. They were hospitalized for many months and were still recovering from their injuries in 1973.

Partly because this accident had a profound effect on staff morale all over the Area, and partly because of frozen and impounded federal funds, Area-wide meetings of all Mental Health and Social Services staffs were held infrequently in 73 and 74. Smaller groups from single discipline or staffs from nearby reservations have had training sessions or workshops together, and there is general hope that Area-wide meetings can be planned again when sufficient funding for travel arrangements can be made to reduce the dangers

BEMIDJI SUB-AREA


RED LAKE
NETT LAKE
WHITE EARTH
Bemidji
FOND DU LAC
GREATER LEECH LAKE
MILL LAC
MINNESOTA
UPPER SIOUX
LOWER SIOUX
PRARIE ISLAND
LAKE SUPERIOR
BAD RIVER
LAC COURTE OREILLES
ST. CROIX
LAC DU FLAMBEAU
POTAWATOMI
STOCKBRIDGE MUNSEE
ONEIDA
WISCONSIN
MADISON
L'ANSE
HANNAVILLE
BEAVER Island
MICHIGAN
LAKE MICHIGAN
Mt. Pleasant
ISABELLA
LANSING

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of driving long distances after a full working day. The pressures that result from trying to attend to both Area-wide concerns and keep day to day operations continuing smoothly have not been solved in Aberdeen, any more, nor probably any less, effectively than in other Areas.

H. Bemidji Sub Area

In 1972 Camile Riley, ACSW, was appointed as Assistant Chief of Mental Health and Social Service Programs with responsibility for a Sub-Area of the states of Minnesota, Wisconsin and Michigan. The Aberdeen Area is so extensive that these three states with their quite different geographical and tribal backgrounds required a specialized focus of attention. Most of IHS staffed programs are at Service Units in Minnesota comparatively close to Bemidji. The tribes in Wisconsin and Michigan utilize contract services provided by the mental health budgets. An IHS Field Office in Rhinelander, Wisconsin provides consultation staffs, including Mental Health as well as other IHS programs.

This movement toward a Sub-Area, which may eventually assume autonomy, is characteristic of a number of other IHS programs as well, and Ms. Riley in her capacity as head of both Mental Health and Social Services is following the general trend. Both Mr. Reisenberg and Ms. Glasow provide her with administrative support and consultation, but the details of program development and operation have been delegated.

It is obvious that the Bemidji Sub-Area is very differently organized from a reservation viewpoint than the rest of the Aberdeen Area. There are small scattered reservations, and pockets of Indian population scattered over three states. In Minnesota the traditional reservation unit functions fairly well for the Chippewa at Red Lake, where there is an IHS Hospital and at Greater Leech Lake Reservation where the IHS has proudly accredited hospital located at Cass Lake. Nett Lake is served by a Health Center as is the Upper Sioux community, but Mile Lac and Fond Du Lac have no regular resources except from the field health personnel. In Wisconsin there is a field station at Rhinelander which services four Winnebago and Chippewa reservations, as well as the Lake Pottowattomie, Stockbridge Munsee, Oneida, and the Menominee who have recently had their federal rights restored after a period of "termination". There is one sizable reservation in Michigan, and about four other small concentrations of Indian population, which are also served from Rhinelander.

Although one does not usually associate prejudice with the Great Lakes area, discrimination seems to be a routine phenomenon of inter-agency efforts. This may not be focused in the direction of Indian people, but rather due to the general shortages of money and a deeply entrenched myth that the Indians have federal resources not available to others and should therefore not ask for a share of scarce local Welfare, or other funding. The staffs report that they truly need a special category on their automated data report forms for recording the problems of inadequate resources provided by state and local agencies and the unfair denial of medical assistance and other supports to which the Indian people are entitled in the same manner as anyone else.

For these reasons, among others, the Community Health Representative Program has great potential in this sub-Area. The existence of trained local tribal persons who can be the first line resource for families with health and social problems, would raise the level of services in any of the Indian populations in these states. Understandably the sub-Area chief of MH and Social Service spends a considerable proportion of her time on the CHR program, in arranging for training as well as in recruiting and supervision.

This activity also falls naturally to a capable administrator who is located in a Field Health Office, and the Mental Health Social Services program is so subsumed throughout the Bemidji sub-Area. In general the few staff, outside those in the two hospital settings in Minnesota, cannot undertake very much direct clinical service. The bulk of the Field staff time is spent in program coordination, consultation with tribal leaders and interagency work, just as is Camile Riley's time at the sub-Area office. Because capabilities along these lines are invaluable to IHS, the social workers even in hospital settings are often called upon to assume administrative functions as acting SUD, or in other capacities which further prevent their developing mental health programs. Concerns for dental, TB and other health and medical problems assume equal, if not over-riding importance both to IHS staff and at times to local Indian populations. The use of contract funds and attempts to work with local CMHC programs characterizes the Sub Area to a greater degree than in any other states where IHS offers mental health services.

V. OVERVIEW AND AREA-WIDE ACTIVITIES

A. Functions of the Area Office

The staff of the Area administration of the Mental Health and Social Service Branch in Aberdeen in 1973 consisted of three administrative persons: Ms. Betty Glasow, Chief, has had a long career in Indian Health Social Service, all of it in the Aberdeen Area. She will retire in 1975 having been on duty continuously since IHS was formed in 1955.

Ms. Glasow handles much of the administrative work at the Area level, including budget liaison with the Area director, and other Branch chiefs. In addition she has consultation responsibilities to a number of the programs, and visits each reservation periodically to confer with Service Unit directors program directors, and community leaders. She is responsible for annual reports of the program, and also receives monthly reports from each Service Unit program.

There are two supporting staff of an administrative level. Camile Riley is designated Assistant Chief for the Bemidji Sub-Area, and coordinates the activities in Minnesota, Michigan and Wisconsin. Her duties are essentially similar except that final decisions on personnel, budget and program planning are referred to the Area office for the chief's approval and action.

Robert Reisenberg, MSW, was designated as Deputy Chief for 1973-74 which meant that in the absence of the chief he could function to approve or implement decisions. In addition he had particular responsibility for developing training programs, negotiating contract services, and preparing support materials on such other topics as the chief requires (personnel, budget, etc.). Mr. Reisenberg spent about half of his time traveling to Service Units as a consultant on program and staff development, and visiting community leaders and conferences where resources can be developed to mutual benefit. In the summer of 1974 Mr. Reisenberg transferred to the Billings Area and this position was not immediately filled.

Secretarial support is provided by Angeline Walth, who has had long and varied experience, and served the Area office for many years.

By October 1972 the combined Mental Health and Social Service staffs had grown to a total of 59 persons, providing services to 18 reservations in five of the seven states of the Aberdeen Area. Seventeen contracts with non-federal mental health resources provided all or supplementary services to 24 reservations, covering at least six of the seven states. Tama, Iowa, which is not geographically connected to any other part of the Area, and which has no regular IHS Service Unit, was home of the only group of Indians not receiving some form of direct and/or consultation services from this combined branch.

B. Career Ladder Development

Of the 59 IHS staff, 35 or well over half, were Indian, mainly in paraprofessional positions. During his period in North Dakota, Mr. Reisenberg had begun developing training plans and a career ladder for the Mental Health Workers and Social Work Aides. As he moved into full Area responsibility as Deputy Chief of Social Service and Mental Health, Mr. Reisenberg combined these ideas with earlier work done by Dr. Burnap. Representatives from all portions of the Aberdeen Area were included in discussion of the position descriptions and training needs for a clear sequence of civil service grades. This was then forwarded for national IHS discussion, but has not yet been implemented in its entirety. The completed proposal is included as Appendix B of this report.

It might be noted that this proposed civil service revision describes a graded series of responsibilities under the generic term Mental Health Worker. Up to this time in the Aberdeen Area this term was not used as it has been in the other Areas. Instead, the paraprofessional employees are given designations indicating a discipline and an apprentice or subordinate status such as Social Work Aide, Social Work Representative or Psychology Technician. This may be a function of the earlier roots of this program in the Social Services Branch which had established paraprofessional and apprentice/tutorial training positions prior to the development of the mental health services as a separate entity. While thereis some shared history of this in other Areas, the designation of paraprofessional staff has always been broadly generic rather than specifically disciplinary except here in the Aberdeen Area. The step toward uniformity of title, and clarification of levels of competence should provide for a better integration at the federal level, and possibly clarify misunderstandings and conflicts about status.

C. Teaching Activities of Staff

Meanwhile specific courses have been developed locally at Sinte Gilleska Community College on the Rosebud Reservation, Pine Ridge Community College, The University of North Dakota at Jamestown, and other educational centers throughout the Area. The availability of these courses mitigates the need for Indian personnel to take long absences from their homes and families to enter training programs at Tuscon, Desert Willow Training Center, and other facilities without contact with local conditions. Some personnel do participate in these programs away from the reservation base. However, the availability of academic work as part of the on-the-job in-service training closer to home permits the employment of mature individuals with family responsibilities. It also permits a closer and more integrated sense of theoretical and practical materials. In some cases IHS staff hold academic appointments and teach the courses, exchanging their teaching for tuition payments for IHS personnel in a variety of complex contracts.

Only in Pine Ridge do the paraprofessional staff take an active role in teaching. This is probably a function of the greater age of the program and the seniority of the paraprofessional staff, one of whom has been Acting Director.* As examples of the range of courses taught by the staffs over the Area are: Sociology, Interviewing, Counselling Techniques, Communications Skills, Tribal Culture and History, Observation and Child Development, Dynamics of Small Groups and General Psychology; as well as in-service courses for CHR's, alcoholism counselors. and headstart staffs.

D. Goals and Format of the Area Program

Mr. Reisenberg has drawn up a description of the mental health services offered by the combined Mental Health and Social Services Branch which gives the contemporary rationale, format or administrative structure, and goals in terms of the range of services to be provided throughout the Area. This document is presented in full before looking at the actual activities carried out in each of the Service Units.

*Confirmed as Director in 1975.

MENTAL HEALTH BRANCH DESCRIPTION
Aberdeen Area Indian Health Service

Problems Which Create a Need for a Mental Health Branch

The Aberdeen Area Indian Health Service administers a number of health programs to provide comprehensive health care to the Indian people. One of these programs is mental health. The Area Social Service-Mental Health Branch is responsible for the planning, implementation, improvement, training for, and monitoring of the mental health program.

As with any health program, the mental health program is intended to contribute to the allieviation of health problems and this is the intent of the Congressional appropriation. While each Indian community is different from others in the severity of various problems, there are several mental health concerns most Aberdeen Area communities share. These form the basis for an Area program:

1) Physical illnesses frequently have emoitonal and psychological causes and/or consequences. The health of the individual can be best restored by including these factors in his or her treatment.

2) Families, individuals, and communities experience a great deal of psychological strain in living with poverty, prejudice, discrimination, cultural disintegration, and lack of control over the community's institutions. This strain can impair social and psychological functioning and thereby reduce people's effectiveness in coping with these problems.

3) Some individuals and families are not psychologically equipped to cope with life's problems and can benefit from therapeutic assistance to increase their coping skills.

4) Many individuals and families face unusual stresses in daily living which may acutely overwhelm their normal coping abilities. Therapeutic intervention may prevent deterioration and improve their coping abilities for future crises.

5) Emotional and psychological problems sometimes lead to institutionalization of patients in facilities far from the home community. This removes family support, prohibits family involvement in treatment, and reduces the prognosis for the patient's recovery.

6) Children are sometimes removed from the community and placed in distant boarding schools for social and psychological reasons. The boarding schools are not designed to allieviate these types of problems, and in fact, the problems are sometimes aggravated by removing the child from his family and community.

7) Effective non-Indian mental health services are usually not available to Indian communities because of distance, non-existence, lack of staff's understanding of Indian culture and life-styles, and sometimes a reluctance to provide services to a reservation population.

8) Where mental health services are available, many Indian communities are reluctant or unable to utilize them due to misconceptions or lack of knowledge about the purpose and content of those services.

A second intent of the Congressional appropriation was to make services available to Indian people similar to those offered across the nation through the Community Mental Health Centers Act of 1963. This Act provided Federal assistance for communities to establish comprehensive mental health services near people's homes rather than in distant State Hospitals. The IHS Mental Health program attempts to make available to Indian people a wide range of community mental health services, and to assist Indian people to utilize non-IHS mental health services wherever possible.

Policies of Aberdeen Area Mental Health Branch

Every program must decide which goals to work toward so that the identified problems may be allieviated. As exact measurements of social goals are not possible for ary social program at present, policies are established which are believed to be effective in reducing the magnitude of the identified problems. The Aberdeen Area policies reflect a community mental health approach to problems and emphasize prevention, community involvement and responsibility, and treatment in the home community. These policies are:

1) To prevent the unnecessary institutionalization of Indian people and provide or secure appropriate treatment in the home community.

2) To provide assistance to individuals, families, and groups in resolving or coping with emotional, family, and community problems so as to prevent deterioration in functioning.

3) To prevent the removal of children from their home community whenever feasible if removal is detrimental to their mental health.

4) To reduce the incidence of individual, family, and community mental health problems through identifying "at risk" populations and providing preventive mental health services whenever possible to those groups.

5) To encourage and assist tribes to develop needed mental health services, to support existing tribal programs, to adopt mental health concepts into existing community programs, services, and institutions.

6) To encourage and assist tribes to gain responsibility and authority in areas affecting mental health when the lack of such authority and responsibility is detrimental to the mental health of the community.

7) To improve understanding and utilization of mental health concepts and services in the community.

8) To develop indigeneous paraprofessionals in the provision of mental health services to the extent that they be able to render professional caliber services independently.

9) To provide a career ladder for mental health paraprofessionals.

10) To provide opportunities to increase the mental health related knowledge and skills of IHS mental health staff, other IHS staff, and other community agency staff.

Format of the Mental Health Branch

The format of a health agency is the vehicle through which policies are transformed from words to actions which will (hopefully) allieviate the identified problems. If this vehicle is inappropriately designed for its environment or has some malfunctioning parts, policy and action may not be consistent or effective. The components are:

1) Indian Health Service employed mental health staff at each Service Unit.

2) Administratively, the staff is under the supervision of the Service Unit Director who has line authority to determine local mental health policy, priority of service, selection and discharge of personnel, rewards and promotions, and expenditure of funds. Only the Area Director has line authority over the Service Unit Director. The Area Office maintains a Mental Health Branch Chief who serves as consultant to the Area Director for the mental health program. In practice, the Branch Chief acts for the Area Director in most aspects of the program. The Service Unit Directors usually are not mental health professionals. They need and deserve a close working relationship with the Area Mental Health Branch Chief to assist them in understanding the range of work possible for mental health staff, the chances of effectiveness of various approaches to mental health problems, the contributions possible to the Service Unit program, and some assistance in assessing the accomplishments and deficiencies of the Service Unit program.

3) The basic staff at a Service Unit is a professionally trained worker and an indigenous paraprofessional worker. To date, a Master's degree social worker has been the first staff member recruited, followed by a mental health worker (paraprofessional). If a third position is filled, it is usually a second mental health worker, followed by a secretary, then a psychiatrist or Ph.D. clinical psychologist. If additional staff is required, a ratio of two or three mental health workers for each professional is typical, depending upon the needs and requests of the Service Unit and the Tribe.

4) Case and program consultation by a Ph.D. psychologist or psychiatrist is provided to each Service Unit whenever possible through a consultation contract with a non-IHS resource or through employment of the consultant with IHS. This consultation is vital to the program and enables the social worker and mental health workers to accomplish more comples tasks than would be possible without consultation.

5) Staff development is carried out in a variety of ways. All workers are expected to develop their skills and add to their knowledge in order to provide a higher quality, more comprehensive service. Supervision of mental health workers is intended to develop skills and knowledge as well as monitor work. Where community college courses are available,

mental health workers are encouraged to enroll. A mental health library is now available at each Service Unit with material suitable for beginning and experienced staff. Consultation (as described above) is also utilized for development of abilities. These forms of staff development are consistently available to each staff member, and can be tailored to individual needs. When Area resources permit, workshops and seminars are provided in the Area Office on topics of general interest to the staff. Also, when financially possible, non-government training courses are encouraged for all staff to provide exposure to recent developments in the mental health field. In the future, staff development should be conducted with program needs in mind as well as individual interests. The mental health staff of each Service Unit should be able to identify its learning needs in order to better implement the mental health program of the Service Unit and the Area. Staff development resources will then be utilized to fulfill those learning needs. Many needs will be similar from Service Unit to Service Unit and may lend themselves to an Area institute, seminar, or workshop. Other learning needs will require individual training. At any rate, we should be able to identify learning needs in line with program needs.

6) Utilization of non-Indian Health Service resources is encouraged whenever alternate mental health resources are available and appropriate.

7) Resources for the Area Mental Health Branch. Mental Health funds and positions are authorized by Congress. The IHS Mental Health Branch Chief allocates the resources to the Areas, and the Area Mental Health Branch Chief acts for the Area Director in allocating the funds and positions to the field. The Mental Health budget is administered from the Area Office and all expenditures must be approved by the Area Branch Chief. It is the responsibility of the Service Unit and Tribe, in consultation with the Area Branch Chief, to make known the additional resources required to implement the Service Unit program. The Area Branch Chief is responsible for establishing Area priorities for meeting needs with finite resources. It is to the advantage of all concerned for the Area Branch Chief to be well informed regarding the program at each Service Unit. Not only does this enable an effective distribution of Area resources, but it also enables the Branch Chief to convey accurate information about the mental health needs at each reservation on the many occasions when communicating with other resource groups and the IHS Mental Health Branch Chief.

8) The program is oriented toward a community mental health model which utilizes mental health and social science knowledge and skills in a public health approach to health care. The emphasis is on prevention after tending to life and health threatening crises.

9) Evaluation of the program is accomplished in these ways:

   a) The Social Service-Mental Health Reporting System records information pertaining to the type and amount of service provided.

   b) The Area Mental Health Branch Chief reviews all operations regularly and suggests constructive changes in cooperation with the Service Unit Director and mental health staff.

   c) When resources permit, an independent evaluation by a non-IHS consultant will be obtained.

Services

When problems have been identified, policies for dealing with the problems developed, and a format for the implementation of those policies established, services to the community are instituted. The Area Mental Health Program attempts to provide eight types of services to Indian communities.

1) Outpatient therapeutic services are provided to patients presenting themselves to the staff, to patients referred by other IHS staff, and to Indian patients referred by other community agencies. These services are available at all Service Units and form the largest part of the workload at most locations. Outpatient services are provided to individuals, families, and groups.

2) Acute Inpatient Services are provided at several Service Units where IHS staff capabilities permit. This usually requires a psychologist, psychiatrist, social worker, or physician experienced in the management of acute emotional disorders as well as a cooperative medical and nursing staff.

3) Emergency services for twenty-four hour coverage of mental health crises.

4) Partial hospitalization for patients able to spend some time in the family or work setting but in need of intensive assistance in the form of psychotherapy, mileautherapy, chemotherapy, or temporary shelter from the constant stress of their daily life. This service requires essentially the same staff capabilities as acute inpatient services.

5) Consultation services regarding mental health problems and concepts are provided to IHS staff, other community agencies, tribal government, schools, and non-IHS medical facilities serving Indian people. Consultation has a dual role of providing technical assistance and developing the abilities of others to deal with mental health problems.

6) Education in mental health concepts for the community is accomplished at every opportunity. Mental Health education takes place in informal settings as well as formal ones.

7) Community development efforts attempt to locate and create opportunities for communities to develop needed services and obtain needed resources to reduce the incidence of mental health problems, to prevent the deterioration of existing problems, or to provide rehabilitative services.

8) Referral services are provided for those patients who may benefit from mental health services not available through IHS or for patients who are eligible for comparable non-IHS services.

The Community's Role

Community mental health programs stress community responsibility. Service Unit mental health staff and the Service Unit Director are responsible for providing the Tribal Health Board with sufficient mental health information to enable the Board to come to informed conclusions regarding the Service Unit program's definition of problems, policies, and services. The plan for increasing the Board's responsibility and authority is designed by the Service Unit Director and mental health staff. It becomes effective after approval by the Tribal Health Board, the Area Mental Health Branch Chief and the Area Director.

For any program to be effective, it must know which problems it will tackle, the policies it is expected to support in tackling those problems, to whom it is accountable for its actions, and which services it can provide to implement its policies and have an effect on the problems. This paper is an outline of these concepts as they pertain to the program that the Area Mental Health Branch should attempt to implement. It is only a beginning and is designed to take the existing program as it is today, provide it with some understandable identity and general goals, and set the tone for future efforts to refine and improve it.

Robert D. Riesenberg, ACSW
Deputy Chief
Area Social Service & Mental Health Branches
Aberdeen Area Indian Health Service

E. Staff Activities Survey 1973

1. Time Allocation

In view of the heavy emphasis on community consultation activities, it is probably worthwhile to look at a tabulation of time and activity distribution reported by a sample of 17 professional staff and 19 paraprofessional staff collected from the Aberdeen Area in the spring of 1973. With the exception of the two psychiatrists reporting, both of whom indicated a 55-60 hour week, the modal time spent at work by this staff was about 45 hours, with relatively no compensatory time requested or available to offset the overtime. The general categories of time distribution are given in the tables below for professionals and paraprofessionals.

Estimated Allocation of Staff Time
Among the Five Basic Activities
1973-74

Aberdeen Area Professionals N=17 Activity	Percentage of Time Spent 10%	20%	30%	40%	50%	60%
Direct Clinical Services	-	1	7	3	2	2
Consultation about patients	3	6	7	-	-	-
Consultation about programs	10	2	1	3	1	-
Learning (professional & academic)	9	1	-	-	-	-
Administrative activities	8	5	2	1	-	-

CONSULTATION ACTIVITES OF IHS MENTAL HEALTH PROGRAMS STAFF IN THE ABERDEEN AREA 1973*

Agencies consulted with	by Professional staff about pateints N=17	about programs	contract	By paraprofessional staff about pateints N=19	about programs	contract
IHS M.D.'s	16	14	1	19	1	0
IHS Nurses	16	7	0	14	1	0
IHS P.H. Nurses	16	9	0	18	12	0
Other IHS Staff	13	14	0	14	6	0
Private Dr's and Clinics	8	3	2	8	0	0
Community Health Representatives	12	5	2	16	6	0
Public Schools	13	5	0	6	4	0
BIA SCHOOLS	12	11	2	12	8	2
Parochial Schools	10	3	0	1	4	0
Head Start	7	9	0	8	3	0
Day Care	3	3	0	2	4	0
State & Co. Welfare Depts	16	12	1	14	10	0
BIA Social Service	14	9	0	15	6	0
Vocational Rehabilitation Services	15	7	0	12	6	1
University Schools of S.W.	0	1	0			
Community M.H. Centers	8	9	2	4	5	1
State Mental Hospitals	14	7	0	14	2	0
Traditional Healers	3	1	1	6	0	1
NIMH	-	1	-	-	-	-
Veteran's Adminstration Hospitals	1	1	0	0	0	0
Project Recovery	-	-	-	-	1	-
Alcoholism Program Counselors	15	15	1	14	8	0
Detoxification unit staffs	7	4	2	5	2	1
Halfway House Staffs	7	4	2	6	3	0
NIAAA	0	1	0			
Tribal Courts	12	8	1	14	2	1
State & Local Courts (non Indian)	10	3	0	7	2	0
Tribal Police	11	4	0	9	3	1
Local Police (Non Indian)	6	2	0	8	2	0
Jails	11	2	0	10	2	1
Legal Aid	0	0	0	1	0	0
Tribal Councils	0	2	0	2	3	0
C.A.P-O.E.O.Programs	0	0	0	0	3	0
Vista	0	2	0	0	1	0
Clergy	0	0	0	0	3	1
Other(Pers. Services)	0	0	0	0	1	0

*Read the table as follows, using first line as an example:16 Of 17 professional staff consulted with IHS M.D's about patients,14 out of 17 professional staff consulted with them about programs, 1 our of 17 had formal or informal contracts to do so. 19 our of 19 paraprofessionals consulted with IHS M.D.'s about patients, 1 out of 19 about programs.

Aberdeen Area Paraprofessionals

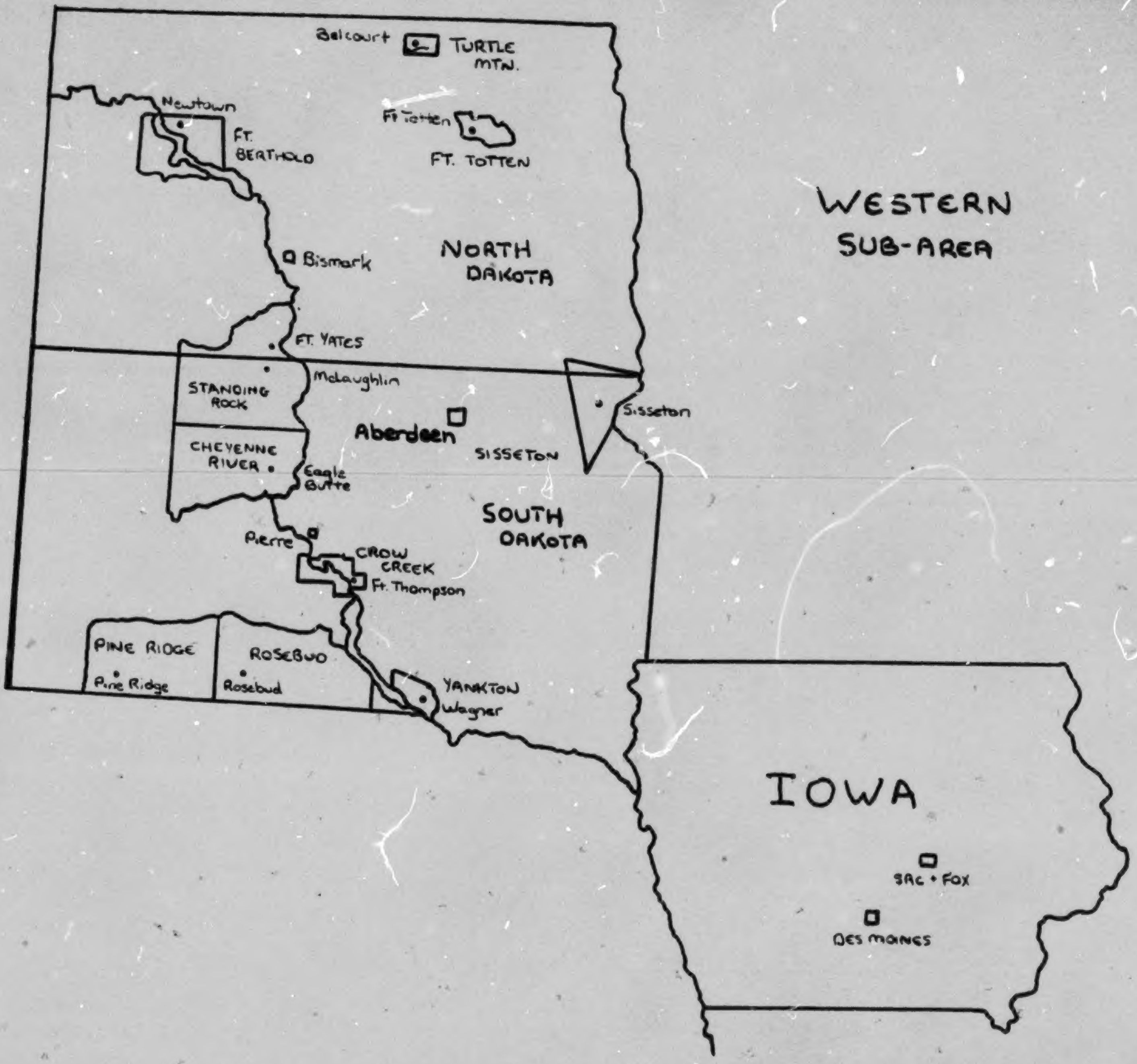
N=19 Activity	Percentage of time spent 10%	20%	30%	40%	50%	60%
Direct Clinical Services	2	1	6	2	8	-
Consultation about patients	10	7	1	1	-	-
Consultation about programs	10	5	1	1	-	-
Learning (professional and academic)	8	3	4	-	-	-
Administrative activities	9	5	2	1	-	-

2. Consultation

A specific look at the consultation activities was requested in this survey and participating staff indicated opposite a listing of agencies whether or not they spent time consulting about programs or patients in each instance. In Table opposite the number of staff who mention either type of consultation is indicated after each agency type. Because of the importance of formal contracts in securing services for Indian people through IHS, a query was made about each agency regarding whether the consultation provided by IHS was formalized into any kind of a contract. There were so few official contracts in any of the Areas that "contract" was defined as including even the informal arrangement of regularly scheduled meetings between the staffs of the IHS Mental Health/Social Service programs and the other agency. The scant number of such contracts, even of the broad informal variety is a pattern similar to that found in other Areas.

This pattern raises questions about the developmental stage and acceptance of IHS services. Are IHS Mental Health Staff still in a selling market, when they must demonstrate their usefulness? Are they slow in organizing their services on other than a crisis or opportunistic contact basis? Or are federal employees taken for granted by other agencies, and therefore called in whenever desired?

The wide network of agencies serving the Indian population, in touch with IHS Mental Health staff, and receiving considerable consultation services is a measure of how well the Mental Health and Social Service staffs are integrating mental health service delivery. However, it may be time for a look at how this can be done in a planned way rather than depending on accidental contacts, mutual seeking out, or crises in the communities involved.


Belcourt
TURTLE MTN.
Newtown
FT. BERTHOLD
Ft Totten
FT. TOTTEN
Bismark
NORTH DAKOTA
FT. YATES
McLaughlin
STANDING ROCK
Aberdeen
Sisseton
SISSETON
CHEYENNE RIVER
Eagle Butte
SOUTH DAKOTA
Pierre
CROW CREEK
Ft. Thompson
PINE RIDGE
Pine Ridge
ROSEBUD
Rosebud
YANKTON
Wagner
IOWA
SAC + FOX
DES MOINES

WESTERN SUB-AREA

VI. SERVICE UNIT CAPSULE DESCRIPTIONS: 1973

One of the first things a newcomer to the Aberdeen Area must learn is that there are several names for most Service Units and reservations. IHS tends to retain officially the name of the older military unit from which the BIA takes its name for the local administrative unit. However, town names, tribal designations, and other place names are in common parlance and daily conversation. In the listing that follows the IHS designation is given first, and then the reservation identification. If other popular usage names are allocated or associated with the Service Unit and the region it serves these are also indicated in the text.

The order of presentation in most official reports is alphabetical; sometimes a double alphabet with larger hospital units being given in order first, followed by clinics and field stations. This has its handiness for reference purposes, but destroys the associations with geographical and cultural juxtapositions that make for the reality of the context within which mental health programs develop. For this reason a geographical listing is given here--starting with the farthest north. Bellcourt-Turtle Mountain on the Canadian border is described first. The order then takes Service Units south and along the Missouri River through the Dakotas and Nebraska. The description of the Bemidji Sub-Area follows similar lines in Minnesota and Wisconsin.

Some programs cannot be adequately described since the source materials are the monthly reports to the Area Office and the quarterly and annual reports to that office. Actual visits to Pine Ridge, Rapid City and Standing Rock permitted expansion of these data, as did a visit to Cass Lake in Minnesota and discussion with the professional staff from other units. Enough information is available, it is hoped, to give a few of the main ingredients, but the true flavor of many programs cannot be incorporated.

The summaries that follow emphasize community activities, consultation and program development. There is a keen interest in this report on the way in which IHS programs relate to the tribal resources and to other service delivery agencies to form a network for Mental Health and Social Services. It is also characteristic of this Area to have a keen interest in these matters, perhaps because of the community organization and referral aspects of the social work background that characterizes most of the staff.

It is also characteristic of this Area that with the introduction of the MH SS data reporting form beginning with fiscal 1973, which provides a computer form for each patient contact, that heavy reliance was placed on this form of reporting to provide epidemiological and case load data. The monthly and quarterly reports therefore emphasize the other aspects of the staff activities, and provide little or no information on patient characteristics except for occasional anecdotal material. Summaries from the computer are not yet available for analysis, so that the direct service activities of staff are under-reported in the summaries that follow. A final report on patient contacts for all Areas for Calendar 1974 will be available in late 1975.

A. Belcourt PHS Indian Hospital: Turtle Mountain, North Dakota

The Turtle Mountain Reservation has been described earlier as being in the far north, along the Canadian border of North Dakota, and the local Indian group is known as the Turtle Mountain Band of Chippewa

Indians. The hospital there has had severe difficulties in 1973-74, and for a period of time was closed. A power struggle between the local Tribal Council and its Health Advisory Board and the physicians and Area Office of IHS has been almost unresolvable during the period when there is a general shortage of physicians. Details are not given here of this problem, except to indicate that neither side saw the Mental Health/Social Services staff as a resource in mediating the problem. Indeed, for a few months the assignment of a psychiatrist to Turtle Mountain meant for him a conflict of loyalities, in which his identity as a physician became uppermost. Dr. Joseph Wakefield had been assigned to act not only as the psychiatrist to this hospital, serving 6100 Indians, but also hopefully to serve as a consultant to the other Service Unit programs in North Dakota.

Dr. Wakefield established the beginnings of a psychiatric service in the hospital, which would enable acute cases to be briefly hospitalized locally, and consultation with the various outpatient and inpatient services. One of his aims was to reduce the abuse of prescription drugs, which seemed to be a main source of supply for those addicted as well as potentially available for suicide gestures. In this he also made efforts to reach and establish relationships with other physicians in the Area. However, many of the general medical officers at Turtle Mountain found conditions intolerable, and left either the Area or IHS service. Dr. Wakefield transferred to Tuba City, Arizona, a hospital on the Navajo Area, after only a few months in the Turtle Mountain setting.

Something of the discouragement that resulted is seen in the brief monthly report filed by Dr. Wakefield for July 1973.

8/7/73 - Belcourt

Things I've tried to do here:

1. direct patient care
2. inpatient hospitalization as an alternative to the state hospital + other institutions.
3. community consultation, (including reducing Rx. drug abuse, in + out of the hospital.)
4. training mental health workers.

#4 never happened. #'s 2+3 are destroyed if the hospital closes, (which it will I think.) #1 is severely crippled by the political agitation.

Not a pleasant month.

Joe Wakefield, MD

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AUG 8 1973
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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Date: 8-13-73
Reply to Attn of: Tom Laws Social Worker Belcourt
Subject: Monthly Report
To: ASS-MH

Activities during the month included;

1. Continued heavy patient load
2. Considerable upset both in our department and in the [illegible] Unit in general due to employee dissatisfaction and or power struggles
3. During the last 2 weeks of the period I was on annual leave.
4. Sorry for the late report

VED
15 1973
BRANCH

Tom Laws

In 1972 and early 1973 contracts with the North Central Mental Health and Retardation Center at Minot, South Dakota, a distance of almost 100 miles from Belcourt, provided a one half day consultation visit per week to the Mental Health and Social Sevvices staff. While this continues to be a referral resource, after Dr. Wakefield's transfer, Dr. Donald Burnap, who had entered private practice in Aberdeen, undertook the consultation contract. His earlier experience with IHS both at Pine Ridge, and in extensive visitations while a part of the Aberdeen Area Office staff gave him background to enter into relationships quickly and to provide consultation appropriate to the realities of the situation.

The staff to whom these consultations are given has remained relatively stable over the period of two years. Tom Laws, Social Worker, and Lance Azure, Psychology Technician, have carried the main acitivites, with Janice Schlenvogt serving as a Social Work Representative. From time to time students assigned for field work experience, especially during the summer months have assisted.

Tom Laws serves as administrative head of the unit, and reports only briefly on the overall situation. The closing of inpatient services and the departure of Dr. Wakefield severely disrupted work with the physicians, so that the programs developed most effectively were outside the hospital setting. Difficulties with securing acceptance of alcoholic patients, especially those in severe distress, had plagued the unit, and with the execution of the contract with Dr. Burnap the report in November revealed how deeply this gulf has remained etched.

Date: 11-8-73
Reply to
Attn. of: Tom Laws, Social Worker
Subject: Monthly Summary
To: Betty Glasow, Chief, Area SS/MH

Activities during the month included:

1. Continued attempts to develop a working pattern for the staff currently working in SS/MH at this Service Unit.

2. Working with the physicians in order to provide care for psychiatric patients. With the exception of alcoholics the current physicians are open to collabaratively providing treatment for mental health patients.

3. Psychiatric consultation now available will be used to provide consultation to physicians concerning psychotropic medication, assist in developing treatment plans, to próvide intervention in instances of inappropriate psychiatric hospitalization.

4. Some time was spent in helping the Indian community in the Treton area better utilize available State and County services

Sincerely,

Tom Laws

Turtle Mountain Tribal Council had, however, established a Counseling and Rehabilitation Board, mainly to work with the problems of Alcoholism, and IHS provided contract monies for a Social Work liaison, training of staff and consultation around problems of detoxification. The amount provided by IHS in '73 was less than half of what it had provided in 1971, and this local institution had considerable trouble remaining viable through the periods of local turmoil and federal fund impoundment. Lancelot Azure, himself a member of the community, acted both as chairman of the Board of Directors and in his capacity as a member of the IHS Mental Health Staff in what were sometimes heroic efforts to keep the cneter going.

The brief excerpts from his monthly reports tell something of the difficulties:

> October 5th, 1974
>
> "During the month of September I took a trip to Washington, D.C. to meet with a few places who were interested in funding different types of programs. The Turtle Mountain Counselling and Rehabilitation Center is essentially broke with no real solid resources coming in at this time. . ."
>
> November 8, 1974
>
> "During this last month I have been working a great deal with the Turtle Mountain Counselling and Rehabilitation Center at Belcourt during its struggle to stay open. Lack of funds has been the big problem for the last year and a half. We have almost come to the end of the line so far as getting credit to stay alive.
>
> I have been involved in trying to raise money to buy fuel to at least keep the building warm. I have been involved in writing proposals to different funding foundations and federal agencies. The future looks good, but the immediate situation looks bad. But we are going to struggle along until there just not any more to do.
>
> November 30, 1974
>
> The Turtle Mountain Counselling and Rehabilitation Center was on the verge of closing and after meeting with the community people, it was decided that there be a community effort to find funds to keep the program going.

By the spring of 1974, turmoil had settled down, and the montly report of Mr. Azure shows that the counselling center is still in business:

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Service Unit Director
PHS Indian Hospital
Belcourt, North Dakota 58316

March 11, 1974

FEBRUARY NARRATIVE

During the month of February, I made a number of contacts working with the Turtle Mountain Counseling and Rehabilitation Center at Belcourt. We met with the Tribal Council regarding the future of the Center and discussed the future funding sources. I also had contact with our Senators and Congressman who sent me correspondence stating that we had won our case to get back the impounded funds held by the Nixon Administration. Funding should start coming to the Center sometime in July of this year if everything goes according to plan.

During the Month of February, we had 14 admissions to our alcohol withdrawal program which seems to be going quite well. We are on call at night for the purpose of admitting a patient who wants to withdraw from excessive alcohol intake.

Other contacts included brief patient contacts involving Social Security Benefits, wheelchair purchases, clostomy supplies, setting up appointments and other such type of contacts. I attended meetings with the Community College in which I serve as a Board Member. I also attended Mental Health Staff meetings.

Lancelot R. Azure
Psychology Technician

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MAR 13 1974
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The heavy usage of the Turtle Mountain Counselling and Rehabilitation Center as a detoxification unit continued, some months reaching as high as 25 admissions and more than 60 days of inpatient care provided, all on a shoestring and with extensive cooperation from all concerned. The time consuming nature of these efforts has led to a specialization by Lancelot Azure in problems of alcoholism, leaving other activities to the rest of the staff.

Earlier than the alcoholism unit, a group home was established for reservation youth as an alternative to jail, or other forms of institutional placement. The choices faced by this institution were largely whether to become a large foster home operation, or a small residential unit along more formal lines.

Interest in children and youth as well as alcoholism has characterized this Service Unit. During the summer Mr. Azure helped develop and operate a youth recreation program which also had preventive and treatment potential for the youth and children. He utilized four local staff and involved a fair percentage of the children and youth of Belcourt.

In addition to these community activities, both Mr. Azure and Mr. Laws had an active case load of around 30 or more patients each a month. While referrals from IHS physicians waxed and waned depending on staff available and the status of the hospital operations, the other agencies and self referrals stayed at a high level.

Janice Schlenvogt, the Social Service Representative, spent much time with chronic patients, especially working with community health representatives and field health personnel in the emotional and practical support of cancer patients. In the good weather she spent a great proportion of her time making home visits at varying distances from Belcourt. She reports that her caseload is largely women from 35-60, many with menopausally related emotional problems.

Ms. Schlenvogt is also extemely useful in contacting residents to engage their interest in services offered by other branches of the IHS Service Unit, such as Diabetic workshops. It is interesting to note that after demonstrating that a successful turnout can be secured, she engages other staff in helping so that her services are not specifically needed and her effectiveness multiplied.

This pattern of working seems an effective use of skills, but she also reports serving as chauffer and escort for long trips to take patients for placement or specialty services. While not inappropriate in relationships--one such trip was to take a patient to the mental hospital, another was related to the placement of an unwed mother in her early teens--these activities often disrupt regular clinic schedules and other planned activities.

By the spring of 1974 another person was added to assist with the clerical load, and as many as 160 patient contact forms were being submitted monthly. A tribally hired and funded social work representative was working in the Dunseith community, mainly with children and their families and with the school.

B. Fort Berthold: Newtor, North Dakota

This Service Unit is located in western North Dakota. The reservation is divided by Lake Sacajawea formed by Garrison Dam on the Missouri River. Two staff members report; Melvin Walker, a Medical Social Worker and Darlene Finely, Mental Health Worker. Their location was in the Minni-Tohe Health Center, maintained by IHS not far from the Fort Berthold area, and in the northern region of the reservation. They seem to emphasize organized delivery of services through community organizations, but indicate a lack of local resources in the area of alcoholism treatment and hospitalization for chronic illness or specialized services. The flavor of their activities is most easily gained by quoting the October monthly reports in full:

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PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

RECEIVED
OCT 10 1973
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Date: September 1973

Reply to Attn of: Medical Social Worker

Subject: Narrative Report

To: Elizabeth Glasow, Chief
Area of Social Service & Mental Health Branch
Aberdeen, South Dakota

Aside from the routine work we sent two Patients with escort to Minneapolis for prosthesis. Two were sent to Veterans Administration (alcholism and alcohol related) at Miles City, Montana and the other to Sheridan, Wyoming this month. An application was made to the National Jewish Hospital in Denver, Colorado for the treatment of one Youngster. One Person went to the T.B. Sanatorium at Rapid City, South Dakota.

The other main activity has been with working with the Psychiatrist in setting up a consultant and in-service training program for agencies such as Bureau of Indian Affairs and the Tribal Programs. We met with some Education and Law Enforcement Staff two weeks ago. Last Wednesday we met with Mr. Gores of Education and Mr. Goss of Social Service - both B.I.A. and the Tribal Judge to formalize the sessions with them.

We have some difficulty in transportation. This week when Mrs. Finley had to make an unexpected trip; I used the Engineer's Pick-up to travel with the Psychiatrist. Also when I have the car Mrs. Finley has had problems in making scheduled meetings on the Day Care Project.

Melvin Walker
Medical Social Worker
Minni-Tohe Health Center
New Town, North Dakota 58763

MW:df

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Date: October 1973

Reply to Attn of: Mental Health Worker

Subject: Narrative Report

To: Elizabeth Glasow, Chief
Area of Social Service & Mental Health Branch
Aberdeen, South Dakota

I have been quite busy with a Day Care Project for the Fort Berthold Reservation for the past two months. The Day Care Committee consists of seven community people. Through the Department of Labor we were able to obtain some financial assistance to hire five Child Care Aides but so far we are unable to find space. The financial assistance we receive from the Department of Labor will probably last until February- but in the meantime our plans are through the assistance of the Office of Child Development, Health, Education, and Welfare, Denver Colorado we are hoping to get funding for a Comprehensive Day Care Program for the whole Reservation with New Town as a Central Station and have five satellite stations which may consist of Whiteshield, Parshall, New Town, Four Bears, Mandaree, and Twin Buttes Communities. The committee has met twice with people from the Office of Child Development for some technical assistance and as soon as we come up with some statistics we will write a proposal and hope for funding.

On October 2, 1973 I attended a one day Workshop in Williston, North Dakota which was sponsored by the Cooperative Extention Service, University of North Dakota. The main topic of the Workshop was "Alcoholism." Knowing alcoholism is the number one problem on the Reservations - it was interesting to know it is recognized as the number one problem in the State of North Dakota, and also to know there are other such Agencies concerned about alcoholism. The Workshop was well attended, organized, and had some very good speakers.

Our Service Unit sponsored a three day Interagency Workshop on Basic Skills in Supervision which I attended. It was offered by the Denver Regional Training Center. The Agencies involved were the Bureau of Indian Affairs, Community Health Representatives, Health Board members, and Public Health Service Staff.

Darlene Finley

Darlene Finley
Mental Health Worker
Minni-Tohe Health Center
New Town, North Dakota

NOV 7 1973
SS-BRANCH

C. Fort Totten, North Dakota (Devil's Lake)

Fort Totten is due east across the state from Fort Berthold. Devil's Lake is one of many formed by melting glaciers in the last ice age.

For the fall of 1973 the staff of the Mental Health/Social Services program consisted of John Ulrich, MSW, and Mary Angeline Alberts, Psychology Technician. In the winter of 74 Mr. Ulrich left and was not replaced until mid-April 74 when Mr. John E. Dick, MSW, reported for duty. During the interim, as well as at other times when Mr. Ulrich was on leave, Ms. Alberts functioned as the complete department, referring to it as 'the social services department' in her reports.

In addition to patient services to individuals and families, this Service Unit developed a number of projects in connection with their consultative and community work. They are listed below as described in a special report.

--Alcoholism project.

We are represented on the Alcoholism Advisory Committee appointed by the Tribal Council. The Committee is involved in on-going efforts to promote and expand alcoholism treatment programing on the reservation, and to provide guidance to efforts already under way.

--Consultation at Mercy Hospital.

John Uhrich officially serves as medical social work consultant to the medical social worker at Mercy Hospital, our 140-bed contract hospital in Devil's Lake. Consultation includes both visits to Mercy Hospital and frequent telephone contacts. The goal of the consultation is improved medical care for Indian patients, and arrangements for consultation have been approved by the Tribal Council and Tribal Health Committee.

--Use of Outside Consultants.

> Dr. Joseph Wakefield, psychiatrist from Belcourt, Dr. John Tyler, clinical psychologist from the University of North Dakota, and others serve us as mental health consultants. Services are rendered both in the community and at the P.H.S. Indian Health Center and include community consultation, individual evaluations, recommendations to our medical staff, and the like. Continued groundwork is necessary for the full efficiency of the program.

Dr. Joseph Wakefield, psychiatrist at Turtle Mountain, made a number of consultation visits to Fort Totten. He was used as a clinical consultant with reference to IHS patients, rather than in any external or programatic capacity. This service was abruptly curtailed when he was transferred to Tuba City, Arizona.

In addition to the psychiatrist, regular contract consultation visits were scheduled by John Tyler, Ph.D., from the psychology department of the University of North Dakota, and for at least 30 visits by graduate students in the clinical and counselling programs of that University. These consultants were used by the staff to review cases, but even more as community resources with other agencies such as tribal educational organizations, Welfare and religious institutions. In this connection and independently, Mr. Ulrich set up closer relationships with the local alcoholism program and with the tribal judge and tribal courts. Quoting from his November monthly report "After considerable effort we succeeded in setting up staff development activities with the Family Development Center of the Devil's Lake Sioux Tribe."

--Regional Interagency Staff Team.

For the major part of his tour of duty Mr. Ulrich was chairman of the Regional Interagency Staff Team, a group of representatives from all local social service agencies who met on a regular basis at the Human Service Center at Devil's Lake. When the chairmanship rotated he remained active with the group and describes its activities as follows in his June report:

> . . .The goal of the team has been to increase communications between all involved agencies to insure better services to clients. The main emphasis during the past year has been in increased involvement with the staff of the State Hospital at Jamestown. Significant improvement of local relationships with the State Hospital has resulted, and the State Hospital staff has become closely involved with local agencies and the P.H.S. Indian Health Center as a result.

Probably it was under this same heading that work was done on eyeglasses for the needy as a special project which the SUD instituted involving many of the staff. This work began in November 73, with Mrs. Alberts interviewing referred patients to determine eligibility and issue authorizations.

--The Brunswick Corporation Project.

The Brunswick Corporation began in August of 1973 building a large factory at Fort Totten which plans to employ about 180 people. Mr. Ulrich describes the situation as follows:

> The community is viewing the coming factory as a real boon, which it certainly is. However, certain problems will result with the coming of the Brunswick Plant and certain profound cultural changes can be expected. Several of my colleagues in the community have staged this fact as an issue worthy of consideration. Efforts are now being made, in cooperation with the local priests, our mental health consultants, and members of the Tribal Council to organize a small group of representatives to act as consultants to Brunswick and to the community in the handling of any problems that may arise.

In addition to these projects established over time, several other single instances of interagency cooperation were noted. Ms. Alberts, for instance spent time giving a workshop at the State Hospital aimed at increasing their understanding of theIndian point of view and perspective, in anwer to their request.

D. Standing Rock: Fort Yates.

Although the IHS Hospital is located at Fort Yates in North Dakota, the Standing Rock Reservation straddles the sourthern border of that state and lies largely in South Dakota. A prominent feature geographically of the reservation is the dam on the Missouri River which provides a wide lake in the North Dakota portion. The tribe has begun development of recreational facilities including a lodge, restaurant, camping and boating facilities. This area is approached across a bridge where the winds whistling through the supports are said to be the voices of spirits of the tribal ancestors. The BIA has facilities at McLaughlin in South Dakota, and interagency coordination, which plays a large role in the activities of the Standing Rock Mental Health and Social Services staff, is necessary to cover a wide territorial range and many rural residents.

James Rixner, Social Worker, and Delores Jochim, Psychology Technician, represent the Mental Health/Social Services staff at Standing Rock. Starting in September of 73, Dr. Burnap made regular visits as a psychiatric consultant to this program. The Service Unit director, a native of the reservation has a keen appreciation of the usefulness of an effective community mental health program, as well as the need for

Mental Health services to patients visiting the hospital. The reservation organization has been quite active in developing special housing projects, recreation and alcoholism programs, and makes much use of the staff's services. The lack of clerical staff makes this unit's reports brief, handwritten summaries. In addition the staff's rather complete identification with the people they serve does not make for easy communication of their activities in a journalistic, descriptive manner. However, a number of projects of the community were defined: One involved work with the tribal council which decided to change from neighborhood centers programs to a Title District Initiative Project using revenue sharing funds becoming available. This really refocused the O.E.O. work on the reservation and consultations also included work with this staff around the financial and administrative aspects, as well as participation in special district meetings and consultation in relation to emergency food programs.

Another project involved consultation with Civil Defense programs for farmers and ranchers and "rural development meetings."

Weekly meetings with the BIA school and dormitory staffs at Fort Yates often included other agencies. BIA Child welfare, Law and Order (tribal) juvenile officers, as well as IHS staff, worked together in solving problems in connection with the pupils at the high school, and attempted planning for more adequate programs and preventive situational changes.

The Tribal Alcoholism program took an increasing amount of the social worker's time as he established both group therapy sessions and staff conferences. Dr. Burnap was also associated with this program as well as the physicians at the IHS hospital.

Delores Jochim spent most of her time in good weather working in the field, especially counselling young women and teen-age girls.

A less well described program has to do with child abuse which involved both Headstart and BIA staff. Considerable effort has been expended to provide suitable care for children who need an alternative to their home living situation, since the tribe has in the past lost a great many children who were placed off reservation by state welfare workers and then were not able to return. The American Association of Indian Affairs has been active in consultation around these matters, and projects plans for sending summer staff who are both pediatric specialists and legal counsel to develop this program still further during the summer of 1974.

All of these community activities come on top of a heavy clinical case load with referrals coming both from within IHS and through outside agencies.

E. Eagle Butte, South Dakota: Cheyenne River

This reservation has a common border with the Standing Rock Reservation and shares the same rolling prairie. The Missouri River angles across it in the eastern portions. It is served by an IHS Hospital which during 1973-74 had great difficulty maintaining its full complement of physicians. At times the number dropped to two, and even one seemed to be continually on duty, but at other times activities ran more smoothly and four physicians were available. This shortage of doctors is a constant problem in the Aberdeen Area because of the remote locations and harshness of the climate, as well as due in some cases to tribal struggles and internal power struggles. The latter two factors do not seem to be a significant problem for the Mental Health and Social Services staff at Eagle Butte, but the shortage of medical resources is reflected in the heavy emphasis in their work on medical auxiliary services such as food supplements for children, assisting in work with families with ill children, providing nursing home placement, eyeglasses, hearing aids and other supporting medical services.

Another characteristic has given Eagle Butte national attention. This is the interest taken by not only IHS but other tribal groups in developing the paraprofessional resources of its own members. A Public Services Career program and other training both on the reservation and off have developed a corps of trained personnel who form a 'pool', for mutual help in developing and maintaining skills and also as an employment resource as new programs develop.

The industrious seeking out of training opportunities, and combining academic work with on the job activities characterizes this staff. During the year both of the psychological technicians, Dorothy M. Clark and Joyce J. Johnson, completed work on their A.A. degrees from Sinte Gileska College at Rosebud, South Dakota. Three students from various programs spent summer field placements with the staff, providing both clerical assistance and program support. The Social Worker, Betty J. Claymore, completed a year's work in Transactional Analysis and began giving courses and workshops in this technique while pursuing advanced training as far away as Fort Logan, Colorado. This too is characteristic of the Eagle Butte Reservation, that training once received is shared widely and eagerly sought by many staffs.

Frank B. Harding is listed as a psychologist with the program and seemed to be involved in teaching both psychology and sociology courses, as well as providing leadership in the development of T.A. expertise and in public presentations of the techniques, as well as working with Ms. Claymore in training alcoholism counselors.

Special projects undertaken by the staff include the organization of services to provide special education services in the schools as mandated by a new state law. Part of this task involved planning with school personnel for evaluations of children and consultation over resource development for children with learning disabilities, physical and sensory problems, and mental retardation. Another aspect of their work was informing parents and the community as a whole of the children's rights to such specialized instruction and educational services and aiding communities in developing appropriate resources. Ms. Claymore and Dr. Harding seem to have taken the lead in this portion of staff activity. Much of this work involved coordination with the state Association for Retarded Children, and included arranging for speakers for the state capitol at Pierre.

The staff, largely through Ms. Claymore, worked on a number of grant proposals such as one called WIC to receive food supplements such as milk for infants and children up to age 4, and food programs for school age children. Not unrelated in interest, but from different funding sources, was the development of SOS, a program to assist elderly Indian citizens with transportation for medical care, shopping, recreation, and food programs.

Crises in the local hospital, or simply new or changed programs are also reflected in the reports of the staff. From March through May a measles epidemic on the reservation took a heavy toll of infants and young children. On April 8, 1974 there were 21 children as inpatients in the hospital and the staff was busy providing emotional supports for both children and families. Later in the month they had home visiting to do in connection with the need to help parents understand the need to disinfect cribs and clothing to prevent infection spreading to other children. Reinfection with the virus and resulting pneumonia was often fatal or caused severe complications in some cases.

In contrast to this work with families of seriously ill children, the month of December saw a large number of children held in the hospital even though they were quite healthy, because their parents were celebrating holidays too vigorously or were otherwise neglecting them. Although some of the staff, particularly the tribal paraprofessionals, visited foster homes and group institutions available through the welfare department, there was strong feeling that Indian children are better off in Indian homes, and a real effort made to secure acceptance by state personnel of Indian foster homes, which could be made available and which this staff could support through emotional and adjustment periods.

The local ministerial groups became concerned about 'the deterioration of the family' and held some joint meetings to determine how they might work together with the mental health group in this area. Parent Effectiveness Training classes was one suggestion to be explored. Counseling with couples having marital problems or getting divorces seemed to be particularly amenable to the Transactional Analysis and quite a number appeared on the case loads, as did a number of teenage girls involved in abusing inhalants. This staff seems quite busy, but stresses its involvement with tribal agencies less than with IHS programs and activities in connection with established agencies.

F. Sisseton

The Sisseton Reservation lies east of Aberdeen, sharing a common border for part of its length with Minnesota, and a small projection into North Dakota. From the IHS Hospital at Sisseton services to Flandreau and Wahpeton BIA schools are provided. The full-time staff consists of two: Louella M. Quinn, Medical Social Work Aide, and Norman B. Landsem, Medical Social Worker. With no clerical services provided, frequent reporting in detail was not typical of this Service Unit program. However, the three summary reports by Mr. Landsem are well organized to give the flavor of the activities in quarterly periods. Excerpts from these give a picture of the involvement of this staff with children and youth, and especially the two boarding schools, Wahpeton and Flandreau.

> In August, we participated with the Lake Region Mental Health Center in putting on a two day Behavioral modification workshop for teachers throughout this county. Attendance and interest was good and we have received a number of contacts from school personnel since the workshop. Inquiries range from requests for assistance in managing behavior of individual students to general areas such as identifying problem students and managing classroom groups. We believe the workshop served the main functions of boosting morale among teaching staff and of increasing concern on the part of teachers for learning and behavioral problems.

Field trips were made to Flandreau and Wahpeton Boarding Schools in September. I met with the pupil personnel staff at Flandreau in a general meeting around behavioral problems, referral problems and enrollment trends. It appears from the statistics, that Flandreau is enrolling more and more students from Michigan and Wisconsin, I am not certain what the implications are but one aspect is that no large reservations or government schools exist in these states and school opportunities are generally limited to the public school systems. This would be an interesting group to follow with some type of study; such areas as adjustment problems, relative maturity and academic abilities are a few of the variables worth considering. Flandreau has instigated some changes around behavioral modification techniques this year in the hopes of changing behavior. One technique is an honor dorm set-up whereby students who achieve certain goals are given special privileges and allowed to move into specially furnished quarters. Another feature is the issuing of activity cards to all students (In the past these had to be purchased by individual students and some could not afford them) and then using the removal of the card as a way to modify behavior. Since the activity card is the key to most campus participation and privilege, the loss of the card can be quite effective. So far, the school is pleased with the results.

The situation at Wahpeton remains virtually unchanged, a mixture of apathy and conservatism. It is just difficult to detect any enthusiasm or progressiveness. The Mental Health program was started in October with the organization of the eighth grade groups. Enrollment is down about fifty students from last year (which is good) and the usual initial adjustment problems are being encountered (run-aways, behavioral acting-out, withdrawal, numerous somatic complaints taken to the nursing department). I am presently visiting the school on a monthly basis to handle certain individual situations as well as participating in staffings.

The concern over drug abuse among adolescents and younger children has been getting some recent attention. A committee is organized including Tribal and School officials to come up with some ideas. The initial step being taken at this time is to conduct a survey among high school students relevant to usage of drugs. There is considerable concern over glue and paint sniffing among children aged eight to fourteen. The Tribal police have "uncovered" a number of community "spots" where sniffing evidence exists. They are taking some steps toward better enforcement as well as identification of abusers.

These interests persist throughout the year as seen in these further excerpts from Mr. Landsem's report for December, January and February.

> I have spent a considerable amount of time in the last three months helping the newly formed Tribal Welfare Committee get organized relative to its functions and operating policies. Under the new Sisseton-Wahpeton Tribal Code, the welfare committee has responsibility for most areas of child welfare as it pertains to local Indian children. This includes foster care, adoptions, guardianships, etc. I developed a foster home recruitment plan for the committee as well as some guidelines for screening foster home applicants and licensing them. In addition, I developed [illegible] of standards for the committee relative to adoptions. These standards were put to use right away as, in January, we had two new-born children released for adoption here at the hospital. There is now some order and process involved in finding adoptive homes for these two children which, probably would not have existed prior to the standards; and the children would have ended up with the first families that asked for them.
>
> Another activity, that I am presently involved in, is in the development of a group home for adolescents. There are very limited resources in this community for adolescents who are either removed from their families legally, or separated through other actions, as a result, a sizeable number of children wander from one home to another, staying only until they are "kicked out" or until that home "falls to pieces". The effect of such a living pattern shows up in poor school attendance, delinquency, suicide attempts and excessive sexual behavior. In fact, some teen-age girls allow themselves to fall into living arrangements with older males as the price for shelter and relationships. The approach we are taking in developing a group home is to solicit assistance from private donors and foundations in sufficient amounts to set up a home for 3-5 years. To supplement any grants received, we hope to be able to arrange contracts with B.I.A. and D.P.W. to cover care for specific children.

Ms. Quinn's activities are more individually oriented, with emphasis on home visits to parents of mentally retarded children, and to elderly people who need assistance, particularly in relation to nursing home placements. She also made daily visits to all hospital patients, and assisted them with referrals to outside resources when needed and appropriate.

In July she reports her participation in a 'clean up campaign for an individual family' carried out in connection with the Public Health nursing staff. By coordinating local resources paint, furniture, bedding, and a water supply to the home were provided, and Ms. Quinn felt that in addition to health and comfort the mental health of the family improved.

The work of these two staff members is specifically supplemented by contract resources. Southeastern Region Mental Health Center in Fargo, North Dakota was given a contract to provide evaluation of students, personal and social development courses for students, emergency services, and participation in program evaluation. This service, initiated in 1972 continues to the present time.

The Lake Region Mental Health Center in Watertown South Dakota was issued contracts for the same three year period to provide evaluations of individuals in a manner calculated to increase the service delivery skills of the Mental Health and Social Services staff—a minimum of 18 per year. It also was arranged under contract that two senior staff, one an MSW and one a Ph.D. psychologist would provide a minimum of four staff training visits during each year with this activity to include staffs of other reservation programs at the discretion of the SUD.

The staff here seems to be focussed on a smaller number of projects than some of the Service Units, and these are reported as discrete units rather than in terms of interconnectedness. That could be a function of the styles of reporting or of the local cultural viewpoint. The report for February and March 1974 illustrates the variety, as well as the consistent follow-up of the activities and projects cited earlier.

UNITED STATES GOVERNMENT

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

Memorandum

TO : Chief, Area Social Service & Mental Health Branch
Aberdeen Area Office - Indian Health Service

DATE: April 2, 1974

FROM : Medical Social Worker
Sisseton Service Unit

SUBJECT: Narrative Report - February - March, 1974.

Activities for February and March have remained active and interesting. In February, I arranged a Seminar on Death & Dying through the Sister Kenny Institute out of Minneapolis. Participants included nursing staff from our service unit, the community hospital and various nursing homes throughout this county. The content covered physical and psychological components of Death and Dying as well as certain nursing functions related to the terminally ill patient. Discussion also centered on working with the family members of such patients. The feedback was positive and most felt their knowledge and understanding of the death and dying process was enhanced. We plan to have a follow-up workshop within six months to a year to serve the function of a refresher course and to cover specific case situations.

Work is continuing on the Group Home proposal. The plan and budget have been developed and a listing of grant foundations has been compiled. We are still waiting on our charter for Incorporation as a non-profit corporation. When that is completed and received, we will begin mailing the proposals out. In the meantime, the welfare committee continues to be presented with placement needs for adolescents with no local placements available. A policy of benign neglect best characterizes the present situation.

The Tribal Alcohol program is closing down its half-way house/treatment center. This program has been housed in an old B.I.A. Day School and a recent B.I.A. inspection resulted in the building being condemned. So, the closing date is set for May. They also plan to close their other program, a child care center, and move the halfway house into this facility. The result of all these changes will leave the program with a halfway house capacity of about half of what it is now and they will have no services for neglected children of alcohol abusive parents. The positions at the child care center will be changed over to alcohol counselor ones.

My trip to Austin, Texas was rewarding both in terms of the workshop content and the personal contacts. We received a lot of information on types of social services, how to improve relationships and communications with other disciplines within the hospital, and how to use consultative services. The joint committee on health standards were also covered in depth as they relate to social services and as they relate to accreditation of member hospitals.

HELP ELIMINATE WASTE HEW COST REDUCTION PROGRAM

Narrative Report - February - March, 1974.
Page 2
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All in all, a very good trip, although my plane sat on the ground for an hour at Dallas and I almost missed my connection at Kansas City. One rather interesting aspect of the meeting was the revelations by a number of social workers who were in the initial stages of setting up a program. Many of them were expressing a great deal of frustration over such things as finding appropriate roles, gaining acceptance by the administrators, doctors and nurses and developing caseloads. Some of the social workers were finding appropriate ways of dealing with these factors, others seemed to be in quite a bind. So, the battle of selling social work goes on.

I have been teaching a mental health course to the high school classes here in Sisseton over the past month. I found the reception to be very good and I am considering presenting a proposal to the school administration to incorporate the course on a regular basis next fall. From my initial contacts with the classes, I have found that the lack of knowledge and understanding regarding mental health is quite gross. If I can increase the awareness and understanding a little, the effort will be worthwhile. The time involved would amount to a couple hours per week.

A field trip was made to Wahpeton, March 20 to meet with the Wahpeton school staff and the mental health staff from Fargo. Discussion focused on a program for the 1974-75 school year. The Wahpeton people expressed an interest in a full-time mental health worker in preference to the program being carried out this year. They believe such a person could do more for the school in terms of meeting mental health needs of the total student body. The cost of a mental health worker (preferrably a MSW) would be around $10,000 for the nine month period. The Fargo center would hire the individual and assign him to Wahpeton. They would then have overall supervision over activities. At this stage Fargo is going to put their ideas down in a proposal and this should be coming in next by next month.

Until next time.

Norman B. Landsem

G. Crow Creek-Lower Brule: Chamberlain, South Dakota

Chamberlain Indian Health Center is actually not on any reservation but is located slightly south of both Crow Creek and Lower Brule Reservations on the eastern side of the Missouri River. The Lower Brule Reservation is on the west bank, and Crow Creek is on the east bank of the river somewhat north of the Rosebud Reservation. These two reservations seem to be sparsely served by other agencies. Both BIA and state welfare have been short staffed, and travel restrictions imposed by budget cuts and the fuel crisis have reduced services by these agencies almost to a non-existent level. Alcoholism, drug abuse by young people, child abuse and neglect, and lack of employment seem chronic problems, accompanied by a rising tide of violence and suicidal behavior. The picture painted by the Social Service Representative who has been the sole staff of joint Mental Health and Social Services of IHS on these two reservations is gloomy and suggests much frustration.

In the late fall consultation from Dr. Malcom Rogers, psychiatrist located on the Rosebud Reservation, was of considerable assistance and by May of 1974 a second paraprofessional, a woman mental health worker already well known in the reservation communities was added. This additional staff and professional guidance contributes to a better morale picture, and suggests that some inroads were being made, but the tremendous social and economic problems obviously challenge the resources available.

The alcoholism programs were tribally operated and are briefly introduced in the July report of Mr. Joseph Davis.

> The alcoholism program in Crow Creek has gone through many difficulties recently, and the constant turnover in personnel has hurt the program a great deal. With the latest changes, though, I feel we have attained some degree of stability once more. I wrote the new federal grant proposal for them, for funding next year; also revised the halfway house proposal. The State Alcoholism Commission has been most cooperative in recent months, and recently granted the alcoholism program a $4500.00 subsidy, to hire a secretary and provide additional transportation funds. The State Voc. Rehab. program has also been very cooperative, and has sent many clients to Riever Park treatment center in Pierre; it has followed up some with offers for schooling and training.
>
> The Lower Brule alcoholism program has been doing very well, but suffered a serious setback last week, when their building was completely destroyed by fire. All their equipment and records were destroyed: also the CAP and the NYC programs were seriously hurt, as they were in the same building. We are seeking emergency assistance funds from the state, as well as from NIAAA in Washington. Temporary quarters have been set up in a hall borrowed from the Catholic Church.

Personnel problems continued to plague the programs on both reservations until well into the winter. In spite of this, however, social reform ideas had become accepted on the reservation as witness the comment in the October report.

> The Crow Creek Tribal Council passed a resolution to treat all alcohol offences as social problems, rather than criminal ones; so if a person is arrested for an alcohol offense, he is given the choice of spending the time in jail, or participating in the alcohol program. The idea is good, but thus far it is not working out very well. The staff is not well trained to handle such a program, and the facilities are poor. A halfway house is really needed to make it work, but there is little hope for such a facility; as it is, the clients have to go home for lunch, and then again for the night. The results are often disastrous as far as rehabilitation goes.

Not until January did the Tribal Council begin to take actions to implement their position.

> There were some encouraging developments in the alcoholism programs on both reservations in the past month. The Lower Brule Tribal Council voted to give the Alcoholism Commission a ranch, with a farm house and several buildings on it, for use as a halfway house

> for alcoholics. They also gave eight thousand dollars to help out the program. The Crow Creek Tribal Council voted the use of a large building for the alcoholism program, for a two year period with an option to renew. They agreed to pay the utilities (estimated at $2400 per year), and gave $1000 for the program. I feel this is a giant step forward, indicating the Councils' increasing awareness of the severity of the problem, and their growing sense of responsibility to do something about it. Also, Stephan Mission gave $500 to the Crow Creek program, and we hope to get $5000 from the State this week. All in all, it was a rather encouraging month in this area.

Child neglect and child abuse, often related to alcoholism, is a recurrent problem to be faced. The January report cites a dramatic case.

> Some severe cases of child neglect in the past couple of weeks, due to drinking; one family of five had to be completely "dismantled"- a baby admitted to the hospital under the diagnosis of starvation, three children placed in one foster home, another with a relative. The most frustrating part about such cases is knowing that the BIA or State Welfare checks will certainly be used to get drunk on, and yet no one seems to be able to do anything about the situation.

This is only one instance of a problem cited by Mr. Davis in his July report.

> One very serious problem is the inability or unwillingness of the tribal courts to take decisive action in cases that merit it, particularly as regards child neglect or abuse. Some parents are chronic offenders in this area, and yet their children are only taken away for short periods of time, and then returned to them. The result is chaos for the child, who finds himself constantly shuffled back and forth, with little security or love. In analyzing problem parents on the reservation now, it can be seen that most of them were raised in problem homes; and they in turn are raising their children in a similar fashion. How to break this cycle is a very difficult problem.

In July attention was focused on drug abuse problems, particularly those involving young people.

> A meeting was held in Lower Brule with a representative from the attorney general's office in Pierre; the tribal court set it up, and related agencies were invited. We discussed the possibility

> of setting up a drug abuse program on the reservation. This problem seems to be on the increase, particularly in the areas of sniffing gasoline, glue, aerosals, etc., and the misuse of pills. There is some evidence that other drugs may be in use now too. The possibility of federal funding for a program is being explored.

However, this attention did not seem to alleviate the problem, since after a few additional mentions the report in April gives a grim picture.

> April was a busy month; quite a large number of people to work with plus a rash of overdoses among a group of grade school children (3rd to 5th grades). The whole community of Lower Brule was upset by the latter happening, and though none of the children were seriously injured, a lot of visiting of the homes of the children had to be done. For the most part, they were "attention-getting" gestures due to neglect or unhappiness of some form at home. Also there was some severe fighting among high school students, that ended up in court.
>
> ....

The fighting and violence seems also characteristic of these reservations. It is a theme first mentioned in the July report in connection with youth out of school.

> Employment for the young during the summer months has become a real problem, with the cutback in NYC programs. The constant complaint of the young is that there is nothing to do: no work program, and no recreation program. Part of the result of this is increasing juvenile delinquency; knives and even guns are being carried by some groups, and occasionally there are stabbings and shoot outs at night.
>
> Two more related suicide attempts (or accidents?) in the past week were alcohol related; one involved drinking pinesol, the other brake fluid. Also there was a killing due to drunkeness, which the FBI is now investigating. [illegible]
>
> This month reflected a continuing deterioration in conditions on the reservations, with two more shootings, at least five more suicide attempts (three overdoses, one slashing, one hanging), several knifings, and one car accident death (probably alcohol related). The rise in violence on the reservations is quite alarming, with some of it originating from family feuds.

Slightly more optimistic notes are struck in the spring. Dr. Rogers' assistance with consultations at the school is noted, and Mr.

Davis seems to be better able to involve himself with the complex problems of some of the counselors and young people. Dr. Rogers began a series of talks with the school staffs on both Lower Brule and Crow Creek Reservations, and was apparently warmly received by the teachers who were struggling with the same difficult situations noted by Mr. Davis.

A nutrition program, providing meals for 50 to 60 elderly was funded and organized, with Mr. Davis serving on the advisory board. With some hope of new staff from both BIA and state welfare, the reports sound a little more hopeful of some realistic changes.

H. Rosebud

It is difficult to get a clear picture of the activities of the Rosebud staff over time, although some services were established there as early as 1970. By July first of 1973 a full staff of psychiatrist, social worker and three paraprofessionals was established in suitable quarters, with back up services from Psychological Services, Inc. of Norfolk, Nebraska. However, it was not possible to visit the Rosebud Hospital and Service Unit, and after October 1973 there are no reports furnished for review and compilation.

From other sources one is aware of many Mental Health related activities on the Rosebud Reservation, in child study and child development programs, alcoholism programs, and suicide prevention. Staff from other reservations have received A.A. degrees in Mental Health Work through Sinte Gileska Community College, one of the oldest all-Indian two-year colleges in the United States. Perhaps because of these resources, together with the absence of open confrontations with the federal and white establishment that have characterized some of the other reservations in the Area, the programs on this reservation have tended to be self-sufficient. Perhaps it is just enough distance from the other routes traveled by IHS Area office staff to be difficult to visit and hard to plan for contact. Perhaps there are other reasons for the absence of information, which combine with both of these.

On the basis of the few reports available several things stand out about this program.

i) It has been furnished new quarters, which the staff refer to as a "Greenhouse", providing privacy for interviewing patients and conference and waiting room space. This is welcomed by all, but there seemed some diffidence from the community, and a need to build up awareness of availability and location. A problem that might have some bearing on this, but might also contribute to the solution is the lack of a clerk or secretary. Volunteers and students in distributive education courses were being utilized, which might well spread the word through the adolescent community about the services available. However their lack of experience and continuity might well leave gaps in communication to be overcome.

ii) As a partial remedy to this problem, and as a way of structuring time and activity a "Duty Roster" was drawn up in September 73, with one staff member to be available and responsible for intake activity, whether by letter, telephone, referral or walk in, during the working day of 8:00 AM to 5:00 PM. This would leave the staff members free to plan their other activities in the community and the field for days when they were not OD and also insure coverage for the five days the service was provided.

This system initially was described as having the intake person responsible for all follow-up on the persons entering the service on their duty day. Presumably this later evolved into follow-up which permitted some referral among the staff in order to take advantage of specialized skills, compatabilities, age, sex, and geographical specialization. However, since subsequent reports are missing, it is not clear what policies were implemented. These types of problems are familiar to most "team" efforts, and it would be helpful to see how they were worked out in this setting.

iii) The Mental Health Advisory Board on this reservation is active, and there is much contact between it and the staff. Since this board also oversees the tribal alcoholism program coordination of services, appropriate utilization of specialists is a real possibility. Again one is tantalized by the lack of specific details. There is mention of the board calling on the Mental Health/Social Service staff to assist in the screening of applicants for the director of the tribal alcoholism program, and of the bard's later confirmation of their choice.

iv) One of the MHW staff was appointed to the Board of Directors of the local Delta Marie Home for Children, and anticipates that this will "initiate more meaningful and co-operative working relationships between the Home and the Public Health Service."

v) Other than these four community related activities there is a clear reflection of the fact that the staff welcome the professional services of a psychiatrist. Some of Dr. Malcom Rogers' consultation work on nearby reservations has already been mentioned, and presumably having him available on the reservation for the bulk of his time is an improvement over utilizing contract psychiatric consultations limited to 15 visits per year, which was all the resources available during 1972 and 73.

vi) Anecdotal material reflected in the reports between July 1 and October 1973 indicate that the range of cases seen do not differ markedly from those at other Service Units, since suicidal gestures, family problems, and need for school or other psychological evaluations are mentioned. As with the other Service Units, the introduction of the MH/SS Automated Data Reporting System in 1973 reduced all motivation to note numbers and kinds of cases in separate monthly reports, so that a clear picture of direct services cannot be drawn, even for these three months.

I. Rapid City Indian Health Service Hospital

The IHS Hospital in Rapid City is a multi-story modern building built in the 1960's. It is affectionately and familiarly known throughout the Area as "Sioux San", a reference to its origin as a Tuberculosis Sanitarium, located near and specially designated to serve the various Sioux reservations located in the Dakotas. By the end of the 60's the epidemic of TB had been alleviated, and only part of the space was needed for the long term and specialized needs of this group of patients. A special Congressional appropriation enabled the Service Unit Director and Area Office to redesign the Hospital so that it could offer a broad range of specialties. This Service Unit functions to offer services to the urban Indian population of Rapid City as well as to Reservation residents. This last service is unique to the Area, since in most other instances Service Units are located on the reservations, or require reservation residence status if questions of eligibility arise.

The Indian population of Rapid City is largely Sioux, and predominantly derives from the Pine Ridge and Rosebud Reservations, although some representation of persons from many tribes are found. Rapid City is the urban trade center for southwestern South Dakota, the Gateway to the Black Hills, to the Badlands, and to the resources of these regions, including tourism. Since it represents a potential of employment not found on the reservations many persons come for varying lengths of time, or even establish working homes in Rapid City while maintaining residence on the reservation proper for parts of their extended families.

A serious flood washed through Rapid City in 1971, and traces of its ravages were still visible in 1973. The still standing but damaged structures in the flood plain are now mainly middle class homes, and some of the luxury suburban type. However, the Indian community had clustered in the bottom lands in far less adequate housing. Some of the homes were actually improvised shacks, some were cheap rentals flimsily built. This area has been largely bulldozed over, so that the scars are no longer prominent, but neither are the homes available. Many of these folk, who did not return to the reservation, as well as some of the more recent immigrants, have been housed in trailer parks established as part of the flood emergency relief, and now becoming a permanent housing for those with low and marginal incomes.

This is not to imply that all the Indian population is poverty-stricken and unstable so far as residence is concerned. There are a fair number who have made successful transplants in business, trades and civil service employment, but they still represent a minority population. In miniature the Indian population of Rapid City appears to resemble that of the large urban centers like Denver, San Francisco and Chicago, with the possible distinction of a major Sioux cultural background.

The IHS hospital serves these persons as well as those referred from the Area Service Units for TB care. Mental Health and Social Service then have a dual task of providing services within the hospital setting and in the community, and of maintaining contact with the reservations of origin of many of their patients. The support of the SUD in developing relationships in the community, and of entering into appropriate community consultation and participation is invaluable in framing a Mental Health/Social Services program. His own activities supplement those of this specialized staff, both in community activities and in leadership and example in concern for the emotional needs and mental distress of both in and out patients. Only a sketchy account can be given here of the work being done by this staff, but it should be documented in greater detail and used as one model for those who become involved in other urban programs.

The Mental Health Social Services staff is a stable one that has worked together for several years. Mr. William Haddow, the Social Worker, has the resources of two paraprofessionals. One of these, Ceclia Lee Rohrbuck, Social Service Representative, has been with the program from almost the beginning. Donald D. Annis, Social Work Assistant, was replaced in March by Gene Dillon, also an S.W.A. They are joined twice monthly by Carl Keener, M.D., psychiatric consultant from Denver. Dr. Keener has had extensive experience both during his residency training and later as Mental Health Chief of the Billings Area, but is now teaching and engaged in private practice in Denver.

It would appear that Dr. Keener divides his time between clinical evaluations of selected patients, or case conferences with the staff and patients, and community consultation activities in which he participates with one or more of the staff. Mr. Haddow carries an active and sizeable clinical case load. Mrs. Rohrbuck visits the TB patients and gives much attention to their emotional needs while away from home. She also has an active case load of girls and women from the community. Mr. Annis has specialized to some degree in working with alcoholism programs both in the community and as established in the "Sioux San" itself.

As illustrations of their community activities, there are the following anecdotal references. The Welfare department in its local office made an arbitrary decision that pregnant girls under the age of 18 would not be eligible for Aide to Dependent Children and its associated services. However the IHS staff secured a ruling from the Regional HEW office to the effect that this was not the intention of the federal agencies providing funds, and the local ruling was reversed in a relatively short time. It is a significant indicator of the confidence the Indian community and IHS physicians had in the Mental Health/Social Services staff that this problem was quickly referred, and openly discussed.

Another community endeavor has been the planning for a Family Development Center by the local Community Action Project in Rapid City. Both Dr. Keener and Mr. Haddow have been active consultants in planning this project, which will have an impact on both Day Care and Headstart programs. Consultations with the Department of Vocational Rehabilitation seem to be mainly case and referral oriented, while alcoholism program consultation includes program development and utilization of resources.

Operation Outreach is a unique program developed in Rapid City. As part of the flood relief emergency funds for mental health services were requested, but federal impoundments and other factors beyond local control delayed the arrival of these funds almost 18 months. At that time it seemed more appropriate to the community to include flood survivors, but to organize an outreach activity around information, referral and brief treatment services using a representative group of paraprofessionals recruited from the problem areas of the city. Both the Service Unit director and the Mental Health/Social Services staff were active in the training of the Operation Outreach staffs, and in collaborative consultation with them in the development of their program. The opportunity to employ preventive public health and mental health strategies was recognized and capitalized upon.

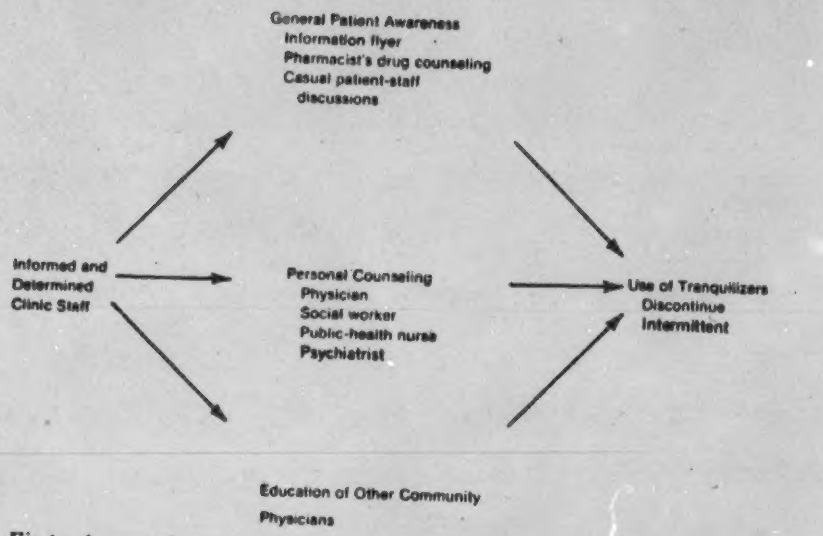
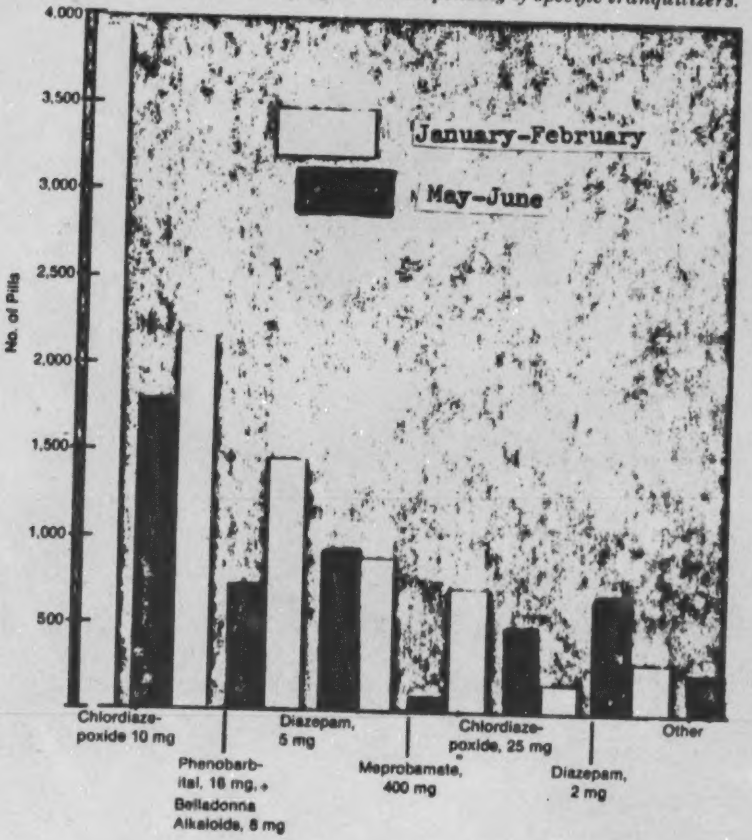

General Patient Awareness
Information flyer
Pharmacist's drug counseling
Casual patient-staff discussions
Informed and Determined Clinic Staff
Personal Counseling
Physician
Social worker
Public-health nurse
Psychiatrist
Use of Tranquilizers
Discontinue
Intermittent
Education of Other Community Physicians

Fig 1.—A comprehensive program for reducing tranquilizer abuse.

Fig 2.—Effect of drug-control program on dispensing of specific tranquilizers.



One of the unique features of the Rapid City program has been the cooperative work with the SUD and staff in reducing the abuse of prescription drugs, particularly tranquilizers and other pharmacologically active calmers or stimulants. Starting with an in-service educational program for all staff in order that they would feel informed, and also comfortable in dealing with the anxiety of patients, the staff then felt able to enlist the community. They distributed a flyer to all patients describing staff willingness to talk about underlying personal problems. During subsequent interviews with patients who came for any medical reason the staff followed up, making appropriate use of the Social Service and Mental Health staff, but finding it rewarding to discuss emotionally laden topics themselves in many instances.

The results have been dramatic, Comparing two typical months prior to introducing the program with two months after its initiation (May and June 1971) there was a drop of 52% in the number of tranquilizing pills dispensed, and a decline of 33% in prescriptions written for such medications. Dependency of patients on meprobamate was almost entirely eliminated.

This project is reported in more detail by Kaufman, Brickner, Varner, and Mashburn in JAMA, Sept. 25, 1972, vol. 221, no. 13 from which the facing figures are extracted.

These examples do not exhaust the list of activities of the staff. Resources needed by individual patients are sought out and appropriate linkages established as far away as Sheridan, Wyoming, Denver and Minneapolis. Active home visiting as well as bedside visits to hospitalized patients are part of what is seen as necessary service, and have become as routine as time and transportation resources will allow. Church groups and their fund raising and distribution come into a fair amount of attention, as do scholarship resources for students in high school and post high school settings.

One disappointment in the community work is the difficulty of making meaningful use of the local Community Mental Health Center. This CMHC is organized along traditional, conservative lines, and neither its staff nor any Indian patients who happen to call upon it feel comfortable with one another. The staff did not seem hostile toward the CMHC over this, but regretted that working relationships had been difficult to establish, and therefore this resource was not available to their clientele.

An outstanding characteristic of this staff is their continual involvement in their own learning. This is not a passive accumulation of credits, although the paraprofessional staff has been engaged in academic work at Ellsworth Airbase, Black Hills Community College and Pine Ridge Community College.

Their active learning posture is well illustrated in relation to the way in which they all three utilize the contract for staff training with Lutheran Social Services of Rapid City. During the fall of 73 they undertook a three session course with that staff in Parent Effectiveness

Training. Almost in the process they began re-designing the content and curriculum so that it applied broadly to more effective communication skill development. This made much of it applicable to interactions between family members of all ages and generations. By March the material was being put actively to good use.

> During this past month the main new development is that of the establishment of Indian Parent Rap sessions. The Rap sessions were initiated by the consultant for the Public School Health Project. Last year I was invited to attend Parent Advisory Committee meetings as a consultant. Although the Health Project is aimed at low income families including Indian communities, there were very few Indian parents who attended. The primarily non-Indian groups began having Rap sessions geared toward Parent Effectiveness Training and found them very helpful. I continued to ask for an Indian only Rap session group and finally the school attempted to have a group of Indian parents meet to discuss huffing (a subject most Indian parents see as a major community problem). I brought one Indian mother to the meeting. She was the only Indian parent who attended. The school then contracted with Dr. and Mrs. George Faussen to conduct an Indian only parent Rap session. The first Rap session was held and ten Indian parents attended plus one non-Indian husband with an Indian wife. Three of the Indian parents were para-professionals working with service agencies. The parents appeared to profit greatly from the session and seemed enthusiastic about returning for another session. There will be six weekly sessions led by the Faussens. The group can then elect to continue with leadership from within the group of disband. It is hoped that the group will choose to continue having Rap sessions.

In similar fashion the staff traveled to attend a traditional Tribal Alcoholism Conference in order to learn more about the cultural backgrounds and lifestyles of their patients, alcoholic and non-alcoholic alike. Travel about the city to acquaint themselves with actual neighborhood living conditions, school and resource personnel, and to meet families in their own settings is a continual theme in their reports.

With this zest for self development, and with the administrative support of the SUD, the active involvement of physicians, and the general wide acceptance and respect of the Indian community as well as its agencies, the Rapid City program appears to be one of the outstanding ones in the Aberdeen Area.

J. Pine Ridge

The evolution of the Pine Ridge program from its earliest implementation to the present is a convoluted pattern to unravel. About 1970, when there was an impetus to spread the Mental Health program to the rest of the Area, one technique used administratively was to allow natural attrition to occur at Pine Ridge, and to fill positions elsewhere on the budgeted funds. As a matter of fact some of this may have been going on even before 1970, and there was much confusion about the accounting for Mental Health budgets at the Area level. The basic attrition at first came in the research component, and gradually this activity was reduced to nothing. The Area office found the types of material produced by the staff for the Research Bulletin were not always consonant with their goals, objectives, and methods of working, and many difficulties in publication and distribution were experienced.

In many ways this is tragic, since some of the factors identified and documented in the baseline studies could be invaluable to any objective research team who sought to understand the tribal struggles, factions, and the confrontations at Wounded Knee in the winter and spring of 1973. The aftermath of these experiences still lingers. Even though the main newsmakers have been released from the courts due to mistrials, over 100 other individuals are still in the ajudication processes in courts in Nebraska, South Dakota and Minnesota. The stress experienced is a constant undercurrent on the reservation, erupting occasionally into incidents of violence or tension. Without time and staff budgetted for experienced researchers, and without the administrative support of the Area office, an immediate application of the data collected in the late 60's to assist in understanding and solving the problems of the middle 70's is lost.

However, several of the Oglala staff were well trained in the early years, and have maintained their roles far better than most professionals could expect to do under similar stressful circumstances in their own home towns. Services are being delivered, and utilized as freely and well as before the troubles arose. What is lacking is a feeling of Area office support. For instance Gayla Twiss was named Acting Director when Dr. Burnap left to develop Area office level programs. Until 1975 she was still "acting". Recognition of the difficulties this placed in her path in recruiting staff and handling administrative details was finally achieved and a change in staff morale is evident.

Staff morale has sagged, especially in the winter of 73, but still remains at a consistently productive level. Although no reports detail the activities of the staff during the Wounded Knee confrontations there seems to have been a concerned effort to remain a neutral resource for all Oglala people who had need of the services. At first chronic patients seemed to get better, as is often the case when a real danger implodes the phantoms of anxiety. However, the stresses of families torn apart by divided political and personal loyalties continue. The problems presented by deaths and imprisonment, and the dreadful uncertainty of not knowing what might happen next are significant elements in stress production.

The Pine Ridge Mental Health Program staff established a rumor-clearance-center during the peak period of stress, and by utilizing back-roads and keeping their field schedules they were able to clarify situations and keep anxiety levels under control. Their exemplary service during this period seems to be recognized by the community as it is healing itself, and their neutral position has enabled them to work continuously without stigma.

The report of Francis Montileaux for the month of January 1974 outlines clearly these shifting concerns, as well as indicates the general atmosphere on the reservation.

> For the month of January I have been engaged in the usual type of patient contacts. The only unusual case was what might be termed a social service case. The case involved helping a young man get his bad conduct discharge from the military, changed to honorable. The case required getting the special forms from the Veterans Administration and contacting former employers and people who would vouch for the veteran's character since returning home. Their statements had to be in writing and notarized. The packet was mailed to Senator James Abourzek's office in Washington, D.C.
>
> I have attended several community meetings where alcohol misuse was the topic. The meetings were called by concerned community members who were seeking answers on how they might approach what they described as "the reservation's biggest problem". One of the issues was, what can be done about the local bootleggers?
>
> It was the general feeling that the office of Law and Order was negligent in it's duties. That is, not enforcing the law that prohibits the bringing of alcohol onto the reservation. It was explained there is a federal law that prohibits Whitemen from bringing liquor onto the reservation and selling it to the Indians. However, this law says nothing about Indians bringing it onto the reservation and selling it to other Indians. At least this is the technicality used by the bootleggers to go free when brought into Federal Court. All in all no one was quite sure where we stand regarding this topic. It is quite obvious there is much revising and updating of this particular law that has to be done by both the Federal and Tribal governments. The question of should liquor be legalized on the reservation was brought up and just as quickly put down. Most of the people present would not even discuss this question. In both meetings no definite direction in which to work was arrived at.

> By the time this report reaches the Aberdeen office a new Tribal President will have been elected or re-elected. As of late there is much tension throughout the reservation. Especially after the primary election. There once again seems to be a split between the people; mixed bloods/full bloods, young people/old people, job holders/ unemployed, etc. There is also a lot of propaganda circulating from both sides and in a few words, it is a very uncomfortable time and place to be in.
>
> Most of the non-professional staff members will be starting college courses this week. I have enrolled for 9 hours (3 classes, two of which will be evening courses).
>
> This completes my report for the month of January.

A planned attrition to a level deemed sufficient by the Area office was mentioned earlier, but in 73-74 further attrition occured which was unplanned. The two social workers were both scheduled to leave. Mrs. Rudy left January 1, and Mr. McGuire was scheduled to leave in August. For several months there was no one to handle the hospital caseload for such medical social work needs as finding resources, protheses, placements and financial aid, field work and patient involvment suffered severe cutbacks since these activities were given no administrative priority. There were also losses in the ranks of mental health workers and Delpha Waters, an early staff members who had acted as secretary-receptionist was promoted to fill a mental health worker vacancy. This activity seems consonant with her interests and much of her past work as an intake person, but it left the staff looking for clerical assistance.

Jay Mason, M.D., had remained a third year when his original commitment was only for two. He had mainly been utilized in a clinical capacity, with some teaching in the local college and some contact with the community agencies over patients. In general, the Pine Ridge staff felt that a psychologist would suit their needs more effectively than another psychiatrist, but at the end of the fiscal year neither seemed to be available.

Nevertheless, work has continued on community activities, especially in the schools. Gayla Twiss has established a screening program for learning disabilities and has involved the teachers in developing special instructional and curriculum materials for the individual needs of such children. This avoids the stigmatization of the label "retarded" where it is inapplicable, and also enables children to remain in their local settings.

Group therapy with latency age boys, referred by their teachers was carried on my Mr. McGuire and a student doing field work from one of the schools of social work. Consultation with schools both public and parochial is a regularly scheduled activity.

Kyle and Wanblee, both at some distance from Pine Ridge could use a full-time mental health worker, but service is given on a visiting basis by the paraprofessional staff.

Brenda Twiss has developed a program for mothers in Manderson, another village on the reservation, as well as an adolescent program with youngsters who are ready to drop out of school. Cleo Marshall regularly attends school board meetings in Red Cloud Indian School and works with the BIA staff of the Pine Ridge School who refer behavior problems to her.

Changes in agency rules, ranging from Social Security supplemental income to admission standards from Yankton State Hospital, call for careful checking by the staff to make sure that Indian people are not being discriminated against, and also for preparing themselves to interpret and advise their clientele. All in all the staff is busy, and even spread so thin, is still quite productive.

A more cheeful note is contained in the April report from Gayla Twiss which suggests that there are hopes that both the communities and the tribe will be able to heal itself and recover a former level of productivity.

> Increasing community interest in the problem of alcohol abuse has begun recently. We are consulting with three new groups with a variety of helping methods. These include Alconolics Anonymous with an emphasis on interpersonal communication skills; A.A. and recreational activities, and the Pine Ridge Ministerial Association is trying to start a Drop-In Center for informal counseling, temporary shelter and food, and referrals to other agencies. Delpha has already begun working in the new housing at Porcupine with a group of community people. This local response toward self help is heartening.

Perhaps as indicative of the improvement in morale, and the continued productivity of this staff in its original model is the production of Standard of Care for the Psychosis, Depression, Alcohol Abuse, Child Abuse/Child Neglect, and School Problems. The tables in the appendix show the characteristic behaviors at five levels of severity, and the goals and modes of treatment appropriate to each. This practical and useful document is presently being circulated through the IHS Mental Health Programs for further revision and application. It marks a fundamental move in the direction of being able to develop models for training and evaluating services. This accomplishment is certainly one of the long-range hopes of the originators of the Pine Ridge program back in 1965, and suggests that some of their aspirations may yet be realized.

K. Omaha-Winnebago IHS Hospital

The Omaha Winnebago Reservation is located just north of the city of Omaha, Nebraska, and about 20 miles east of Sioux City, Iowa. It is a divided reservation, originally allocated to the Omaha tribe native to the Nebraska region. Later displaced Winnebago bands were located on its northern section, and what was to have been a temporary sheltering for the winter evolved into a permanent settlement. The two tribes have different language and cultural origins, and often do not share points of view and perspectives on their problems.

The basic plan for the Mental Health and Social Services for this Service Unit envisioned a professional person (social worker), and two paraprofessionals, one to serve each of the tribal groups. Ms. Rosalie St. Cyr, a Winnebago, has had the longest service of any of the staff and finds herself quite busy with the problems of the Winnebago portion and the patients admitted to the IHS hospital located in that section. Securing and holding paraprofessional staff for the Omaha section of the reservation seems to have been a problem over the years, with considerable turn-over and long gaps between hirings. The use of students, particularly those native to the community has partially alleviated the problem in the summer-but does not provide continuity of effort. Hopefully the situation is stabilizing in 1974,

There has also been considerable turnover of social workers in this Service Unit, and it has not always been easy for a new social worker and an older, experienced paraprofessional to find the appropriate division of roles and appropriate relationships. At the present time it appears that inter-agency consultations are handled on a formal basis by the social worker, while the more personal aspects of utilizing resources, giving supportive counseling, and responding to expressions of family needs are the province of the paraprofessionals.

The work of the staff has been supplemented by contracts with Lutheran Social Services of Sioux City, Iowa, and beginning in the spring of 74 with Norfolk Regional Center and North Eastern Mental Health Clinic of Norfolk, Nebraska for similar consultation. Psychological services are also provided on a contract basis by Harry Saslow, Ph.D. of Omaha, Nebraska for three visits per month, under State of Nebraska auspices.

All of these arrangements point to a fragmentation of staff attention and loyalties, and the need for clear communication and planning, as well as in-service education. Twice monthly meetings for in-service training are mentioned, but no outline of content or plans for these sessions is available.

Early in the history of this program a contract through IHS gave monies to the Tribal Alcoholism Program with the expectation that it would handle its own case loads and hire its own staff. As in many other places, this has not worked out, but there seems to be a double bind experienced, particularly by the paraprofessionals who are not sure how far they can go in developing alternative services for alcohol-related problems, but whose greatest volume of case load seems to involve persons with problems accentuated if not casued by alcohol abuse. The futility of repeat use of the Regional Center at Hastings, Nebraska, and the in-effectiveness of the local halfway house program are causes for concern. The intergenerational effects of these problems are reflected in several of Ms. St. Cyr's reports.

> This worker has tried to mediate in a family situation that is extremely complex. Mr. and Mrs. "X" are both middle aged who are both alcoholics and have a son who is also an alcoholic. The son recently alledgedly beat his wife to death and is awaiting the fall session of the federal court to hear his case. He is being charged with 2nd degree murder and has four children ranging in ages 2 to 8. The son continues to hold his job while his parents care for his children. The son and parents continue to drink quite heavily and are attempting to decide what to do with the children as far as who these children will legally belong to after he (father) is sentenced. After much extensive work has been done with this family and becoming aware of many facts of the situation, I have encouraged them to give much thought to foster placement for these children in the best interest of the children. Many of the facts told by family members to this worker are confidential but the question of why the grandparents could not keep the children would rest upon the decision that the grandparents make regarding help for their own problems first.
>
> Counseling with alcoholics seems to be the largest percentage of my activities and no doubt will be for sometime to come. Many, I refer to the Half-Way House for further rehabilitation and some to Hastings Rehabilitation Center. There are as many females as males who are excessive drinkers so this entails much more extensive work when it is a mother who also has a drinking problem. Keeping children in school properly dressed and fed, etc.
>
> For the month of December the number one priority problem continues to monopolize the heavy end of my caseload. Many of the regular alcoholic clients have been currently jailed thus entailing much planning for their release. There isn't much as far as resources other than the local halfway house which most of them do not wish to enter. The reason for this choice I feel is, they are not really sincere in wanting to talk about "drying out". It is disheartening to have to see them continue on in their drinking until they themselves can make up their minds to quit. I have been doing much counseling and assisting them in finding employment, housing, furniture, etc. The rehabilitation phase of any plan for any one of them is usually AA or Hastings Regional Center in Ingleside, Nebraska. Many of the alcoholics have been through Hastings program and cannot gain anymore from another trip there. Many children and also the spouse of the alcoholic are becoming aware of programs and organizations that are available to them such as Ala-teen. These organizations are all in the Sioux City area and that is 20 miles away causing a problem of transportation. I plan to arrange some type of regular transportation for interested families until such time we

> community people can start our own program here in our own community. The response has been excellent from the mothers (spouse) and teen-agers so I am looking forward to organizing or assisting someone who is a community organizer get our own program.

Nursing home problems, usually having to do with placement and with the difficulties of emotional acceptance both by the elder and the family involved, are a thematic concern of Ms. St. Cyr. She notes that a number of patients at the IHS Hospital could be as well or better cared for in a nursing home, as well as reducing the load or the hospital staff. There is indication that she is initiating community discussion that may lead to the tribe attempting to build or attract a nursing home onto the reservation. This would reduce distances to that families could still keep in touch. It should also permit the cultural variations in life style, diet, and language to be incorporated so that the nursing home itself would be less of a depersonalizing institution. However, at this point in time the recognition of need and potential solution by the IHS staff is a long way from being implemented by the community.

Concern for the needs of children is expressed by all three staff members. Mr. Hamilton works with the Tribal Council on plans for a group home to replace the use of state institutions and welfare department foster homes. Ms. St. Cyr becomes involved in cases of teenagers, particularly those of un-wed mothers. Her reporting of one case is included because it indicates the difficulties of coordination when non-IHS and non-local resources are used without incorporating the information and skills of the local staff--who are yet given responsibility for follow-up services.

> There is also another case which involves a 15 year old girl who is expecting in February whom I have been working with closely. The family is a stable family and requested some advice and assistance in planning for this girl. At first it was thought best to relinquish the child but after the girl's latest appointment with the Mental Health Team from Norfolk, the family decided they would keep the baby in the home. I did not agree this was the best plan for the girl or baby but this was a final decision made by the girl's parents. Perhaps there is still time for another change of decision in best interest of both the girl and the baby. Again enters the cultural factor which I can feel and understand myself. The girl feels she must obey her elders, which is in effect her way of showing respect.

Work with schools seems to be of interest to Mr. Hamilton who mentions his relationship to St. Augustine Mission, Winnebago, where he was able to fill in during a period while they operated without a school counselor. However, the major concrete activity in relation to young children seems to be that of the newly added paraprofessional serving Macy, in the southern Omaha section of the reservation.

> I had felt one of the major needs at Macy was to work in the school where so many problems exist with students in all the age groups. Mrs. Klusock to seen the great need. So, together we formed a therapy group of sixth and fifth graders. It has been so much of a valuable learning experience for me and is proving to be very helpful therapy for the students. Every Wednesday and Friday I set up appointments for individuals and do follow-up work for the therapy groups at Macy.
>
> Mrs. Klusock and I are hoping to form other groups. Concentrating more on the upper grades where the problems in their home lives, glue sniffing and teen age pregnancies are very prevalent.

While these problems are general ones, the specific problems of finding appropriate resources for mentally retarded children pose additional difficulties. The network of resources that can be involved is sketched in the understatements in this paragraph from one of Ms. St. Cyr's reports:

> A 10 year old retarded boy has probably been the highlight of my caseload this month. Our county is not in Region 4 which has the best set-up for a foster home arrangement. This makes it quite difficult to place him but the head office in Wayne, Nebraska and also the Lincoln Office of Mental Retardation in Lincoln, Nebraska have been most concerned and helpful in this placement. Testing and evaluation are going on at this time for/with the boy and hopefully by the end of January he will be in a foster home arrangement in either Lincoln or Omaha. He comes from a broken home and he is also illegitimate. His mother has a drinking problem and is a resident of Wisconsin but now plans to live in Nebraska permanently. The Remedial Ed. Teacher in the local Public School has also been another resource contact who is in on the planning for the boy.

Not as optimistic is the feeling about the cooperation of state and county officials when commitment to state hospitals is involved. This part of the country is struggling with the problem of state responsibilities and federal regulations, over who should care for such persons. In addition, the follow up and after-care services provided by the State hospital are not extensively available to the Indian population, and this leaves the IHS staff with problems when the patient is discharged back to the home and they have few guidelines to follow.

In general the dedication and capacity for work of the paraprofessional staff seems unquestioned and the organizing ability of Mr. Hamilton is developing an effective liaison with many agencies.

L. White Earth, Minnesota

George W. Lefebvre, Social Worker at the White Earth IHS Hospital, was asked at the beginning of fiscal 1973 to assume the duties of acting SUD. While his prior work with the tribe and the social agencies made him well prepared for these duties, he was perforce required to devote most of his time to administration of a unit going through tremendous reorganization and other trials. The lack of physicians and other personnel, including medical technicians, pharmacists, etc., meant that everyone available had to turn to and perform whatever tasks were needed to keep services flowing as needed.

In the past Mr. Lefebvre had been active as a consultant to a detoxification center which continued to serve not only IHS needs, but the total community, Indian and non-Indian alike. In its first quarter (April through June of 1973) this detoxification center handled 100 admissions. Three active A.A. groups of over 40 members formed on the reservation. This activity continued, with such support as the social worker could give it.

The tribe through its Business Committee requested funds and training for 10 CHR's and this was enthusiastically supported by the SUD/Social Services/MH Services. Since there were no mental health workers or social work assistants, and since CAP was reducing its Homemaker services, the need for CHR's to fill the gap and provide individualized care was appreciated in all three roles. IHS support and integration of the program with its own services was quite evidently available and offered. Indeed it appeared that this was the most viable method of extending services to the field, even when a physician was recruited and staff of the clinic returned to normal.

M. Greater Leech Lake--Cass Lake Indian Hospital.

During the 1972, 1973 period this Service Unit had the services of Mr. Edward Byrnes, Social Worker. He spent a great amount of his time in local consultation, as well as in direct clinical services. One area in which real progress was noted was Mr. Byrne's ability to serve the Alcoholism programs energetically without detracting from their development of autonomy. He served on the Advisory Board of the Cass Mineo Detoxification Center until it was safely entrenched under the auspices of the Upper Mississippi Mental Health Board and assured of professional and funding support. IHS services then subsided to a level of referral of individual patients for evaluative consultation, and available program and training consultations as a regular on-going service. Throughout this period cordiality and mutual respect were maintained.

Through use of casual contacts with hospital physicians the Social worker interested the staff in developing a staff conference on otis media, and the impact of hearing loss on the Indian population. The probabilities of this again being an autonomous on-going project with IHS and the community involved are good.

It was of real importance that Mr. Byrne's work was oriented toward developing self sufficiency at the local level since he left the program in 1974.

N. Rhinelander Wisconsin Field Health Station

Mental health and Social Services for the two states of Wisconsin and Michigan are centered at Rhindelander Wisconsin with some contract funds for direct services in particular areas and for specific needs. The staff consists of Mr. David Folz, Social Worker, and Mr. David Besaw, Psychology Technician. The division of work between the two is not clear, although it is apparent that when Mr. Besaw, representing an Indian point of view has no luck negotiating with an agency, Mr. Folz can often follow him in a few weeks, and re-negotiate from a position of power due to his white professional status and his ability to have some recommendations about IHS funds.

Mr. Folz has been interested in comprehensive and coordinated services either as integrated into Health Maintenance Organization models or as part of a human services project in various parts of his region. He has visited private and publicly sponsored organizations of this sort and has held or participated in many such discussions among his colleagues.

A particularly sticky problem over several months has been the work with the Lac Courte Oreilles Tribal Council over the possibility of changing the sources of their health delivery system. The tribal leaders have had an idea bout initiating a tribal PHN program, but were apparently about to prematurely terminate their contracts with the local County Health Department before developing their own capability to replace the services.

Considerable energy is devoted to developing training programs at the state level for CHR workers. This program involves the cooperation of the Division of Family Services and other state agencies in Wisconsin, who were organized into a two-day information meeting about all types of services available in the state, how to get services, and who to go to when they are not forthcoming. It was so successful that a second two-day conference was being planned for the spring, to focus on Indian problems and teach skills and concepts of community organization.

In the Michigan peninsulas there are significant problems involving small groups of Indian people, with whom the IHS has little direct relationship. This problem was addressed in a conference of state and tribal leaders in October, with apparently constructive results.

On October 3, there was a meeting in Lansing, Michigan with the staff of the Michigan State Department of Health. This meeting was called by Dr. Rizen to coordinate the services of all the health providing agencies in Michigan. Dr. Rizen was ill and in his place Dr. John Isbister sat in. The State of Michigan sent representatives from the State Department of Health, Department of Management and Budget, Department of Labor, OEO, and Migrant & Indian Health Task Force. Representing the Indian people were Mr. William LeBlanc of Michigan Indian Commission, Mr. Fred Dakota, Chairman of the Keweenaw Bay, Mr. Leon Kinne, Coordinator of Michigan Indian Rural Health Board. Attending for IHS were Mr. Michael Randolph, District Sanitarian, Marquette, Michigan, and the writer.

The main focus of the meeting immediately became the Michigan rural off-reservation Indian people. All concerned felt there was a definite problem, since these people lived in isolated little groups, and number somewhere in the vicinity of 12 to 14 thousand. They are powerless and do not receive good services. The Health Department felt the answer was to use existing resources. In addition, since the Michigan Rural Health Board had been funded by IHS, some machinery to deal with the problem has already been established.

Michigan State Health Department has requested from the Michigan Legislature $36,000.00 to provide three Michigan Health Workers based on the IHS-CHR program. At this time it is undecided where they will work and what agencies they would be attached to. There is a possibility they may be attached to the local health departments, or if the Rural Health Board becomes operational, they may be attached there. Michigan will also coordinate the early and periodic screening and diagnostic program and will advise all its Local Health Departments and County Departments of Social Service to focus on Indian people.

Michigan Indian Commission will work with Indian people as usual and has been dealing with the off-reservation people. IHS involvement so far has been the funding of the Michigan Indian Rural Health Board. At this point, obviously, it is not known what further involvement IHS will have, in so far as actual funding of programs or provision of health care would be concerned. Technical assistance is already available.

Not all the activities were directed one way. The culmination of a year and a half's work was the presentation of a training session involving the Great Lakes inter-Tribal Council, and especially its welfare committee. This program utilized skits and other means of interrelating the human behavior, traditional cultures and problems in face to face agency personnel contacts. Similar programs for non-Indian groups were also suggested by some of the reports. Mr. Besaw played an active role in the creative development of skits for this purpose.

Dental services are badly needed by rural groups, and coordination of a volunteer dental program through the Michigan Dental School at Marquette was a major undertaking not usually falling into the province of Mental Health and Social Services.

The number and range of such programs at a state level contrast with the specific individual cases that absorb almost an equal amount of time and energy. Mr. Besaw's report for December 7 gives an example that can be multiplied, with variations many times over.

> During the week of November 12, 1973, I attended a meeting with Dr. Judy Ladinsky, University of Wisconsin and two of her assistants. Dr. Ladinsky is the project director of a program to bring three out-reach medical clinics near the Lac Courte Oreilles Indian Reservation. Mr. Baker, Chairman, Lac Courte Oreilles, questioned Indian Health Service support of this project. He stated he would not support this project and, further more, Indian Health Service should have some action on the proposal Lac Courte Oreilles has submitted to provide a nurse to the Reservation. Mr. Baker asked us to leave before we had adequate time to explain this project, and further stated, to quote, "stop wasting his time". It is my understanding that this project is not dependent upon the Indian support, if funded the clinics will become a reality, therefore, I felt it was our duty to inform the Lac Courte Oreilles Tribe of this project as a possible resource to the existing Indian Health Service funds.
>
> . . .

The climax of all experiences during the year was the involvement of this team in a TB outbreak. Mr. Folz' report describes this with comprehensive detail in late January 1974.

Most of the month was taken up by an outbreak of TB on the Lac du Flambeau Reservation. A complete report of this situation will be made at a later date when statistics and final reports are completed by the State Health Department and County Public Health Nurses.

A listing of contact and resource people follows:

1. Dr George G. Handy, Administrator of Wisconsin State Division of Health
2. Dr. T. Preizler, Preventable Diseases Section, Wisconsin State Department of Health
3. Mr. Tom Kelly, Regional Administrator, Rhinelander Region, Wisconsin State Department of Public Health
4. Mrs. Jan Egger, Supervisory Nurse, Rhinelander Region, Wisconsin State Department of Public Health
5. Dr. Ashe and Dr. Resan, Lakeland Medical Associates, Woodruff
6. Mr. Art Schuetze, Clinic Administrator, Lakeland Medical Associates, Woodruff
7. Mr. Tom Maintland, Administrator, Pure Air, Bayfield, Wisconsin
8. Dr. Markahm Fisher, Resident Physician, Pure Air Sanitarium
9. Mrs. Frances Edwards, RN, Pure Air Sanitarium and staff
10. Mr. Bowman, Lac du Flambeau Public Schools
11. Miss Betty Numrich and Alice Crass, Vilas County Public Health Nurses
12. Judge Frank Carter, Vilas County Judge
13. Mr. William Wildcat, Chairman, Lac du Flambeau
14. Tribal Council and Health Committees
15. Dr. George Browning, Washington IHS
16. Mr. Ed Leveille. Staff of the Vilas County Department of Social Services

The TB problem came to our attention December 6, 1973, when it was discovered several of the Head Start children probably had tuberculosis. On December 19, 1973, a discussion was held in front of the Tribal Council including representatives of the State Department of Public Health, Indian Health Service, and Lakeland Medical Associates. A course of action was supposed to be decided upon, however, there was some difficulty as to who would be responsible for handling the solving of this problem. The Lakeland Medical Associates stated they wanted to handle the whole problem, however, they would essentially charge for what could be available free from the State Health Department and Pure Air Sanitarium whose responsibility it is to deal with these types of situations. In addition, the clinic originally refused to make special appointments for follow-up X-rays and other things which would need to be done. Since, in fact, people would have to be sent from Lac du Flambeau down to the clinic without appointment for X-rays and follow-up, it was strongly felt that we would lose too many people. Therefore, decision was made to have the County Public Health Nurses administer the Mantoux, which was PPD skin tests and to have Pure Air Sanitarium bring their portable X-ray unit down so that immediately after reading the skin test, X-rays could be given, records could be available, and sent to the local physician, county nurses, and State Health Department.

During the week of December 17, 1973, Mantoux tests were given to 1,430 people in the Lac du Flambeau area. The X-ray unit was set up and the skin tests were read that week and Chest X-rays were given to over 115 people that week. Preliminary statistics show 11 active TB cases requiring institutionalization, 5 probables requiring further diagnosis and over 100 people who will receive INH for a year. These statistics are really not that reliable at this time, and full statistics will be provided later.

Most of the month was spent coordinating and getting the show on the road and having people talk to one another and getting things done, as well as doing the follow-up and finding those people who did not come in. You would not believe the problems between the various agencies when it came to responsibilities and carrying out their functions. The basic problem was still the fact that Lakeland Medical Associates advised that they would not cooperate unless they could handle the whole thing, and yet showed no ability or capacity to really handle the problem. This situation has pretty much been resolved at this time through literally 100's of contacts and phone calls and a follow-up is being done at this point and the situation seems to be well in hand. In early January, either the 12th or the 19th, a meeting will be held between all parties to discuss what happened, how many, and what steps need to be taken in the future, which will include another clinic within the next three months, as well as stressing of the taking of INH for those positive reactors.

The organizational response of the people of Lac du Flambeau was wonderful and in some ways overwhelming. Congratulations are to be extended to the people who worked hard and got this problem under control. Needless to say, there was a good deal of fear which motivated people to come in, however, it would have to be said that this would have to be one of the most successful TB Clinics which has basically reached over 95% of the population. As noted, further report will be followed and the situation should be entirely cleared up by mid-January.

These are selected highlights to illustrate the range of activities of this staff which rivals that of several much larger staffs operating in smaller areas. A fuller description of this type of operation, and some realistic idea of the required staffing would be worthwhile as the program is unique in many ways.

VII. SUMMARY

A. Problems Yet to be Resolved

1. The integration of services between the two branches, Mental Health and Social Service, is not smooth and orderly. Funding, having its sources in two budgets, continues to be a problem in accountability and flexibility. The Social Services budget is part of the general appropriation for IHS to the Area. As such it is subject to local re-adjustments, approvals, and restrictions to meet local and Area needs. The Mental Health budget is a separately appropriated budget and some of its items are not subject to local or Area discrimination. The items for which monies are appropriated, often in both budgets, such as travel of staff and training of staff, are often based upon different philosophies and priorities. In some instances they are not interchangeable. Confusion arises when for instance, there is an Area budget freeze on positions and hirings or promotions out of the Area budget, but still funds available in the Mental Health budget for implementing plans. Similarly in matters of travel, Area Social Service may be subject to local restrictions while travel for community work and for training meetings is available in the Mental Health budget. Mechanisms for equitable resolving of these problems are not always clear, and administratively it is difficult to apply all decisions fairly. Reconciling the two budgets so that everyone concerned can understand how decisions are made has been a problem from the beginning, and still continues.

2. Throughout the Area there is more fractionation and split loyalty than seems health. The Area Office itself is distrusted by the Service Units to a greater degree than was experienced in any other

Area visited. The Service Units often find themselves working with a population that is split into factions--and in which the turmoil makes for instability and dissatisfaction as illustrated in the Fort Belcourt, Pine Ridge and some of the Wisconsin reservations particularly. While the characteristics of these disputes and their etiology are complex, a mirroring process seems to be involved which makes it difficult to tell whether the Area office/Service Unit problems or the Tribal situations are reality or the reflection. Similar unresolved tension surrounds the status of Indian programs in relation to state services in every state in the Area. Perhaps in some ways the problems of the clarification of roles between BIA and IHS in the boarding schools has been understated in the reports of this Area because this situation is so prototypical of the Area as a whole, instead of being a more singular example of conflicting ideologies and policies as it is in other Areas.

3. Possibly related to this split has been the lack of utilization of the contribution of the research component of the Pine Ridge model program in planning and developing programs. To a certain extent the complex total picture of the reservations revealed in That These People May Live is disturbing because it poses questions in a larger framework than can be solved by IHS alone. However, the loss of support and leadership in formulating a role for IHS and for Mental Health and Social Services within or as an extension of IHS policy has pinched back growth that could be made. Planning for Research and Evaluation is needed by most Service Units, as well as time and dollar allocations that permit it to be done appropriately.

4. Staffing of Service Unit programs often suffers from lack of supports as basic as clerical staff, as well as from unrealistic planning for program delivery of multiple services beyond the capacities of staff, however willing. This is particularly true of the need for recognition of the time and expense involved in work in people's own homes, in schools and in other community agencies. Both Clinical services and Consultation require mobility and time allowances for travel.

5. With a few notable exceptions the IHS Mental Health and Social Services program has not had an impact on the medical staffs and the delivery of health services in hospitals and clinics in a fashion designed to minimize emotional stress on patients and families. Even those programs where this is achieved temporarily have difficulties because of the turnover of personnel characteristic of the IHS in general and the Aberdeen Area in particular. One or two instances were found where SS/MH personnel moved into administrative positions, and seemingly thereby were shorn of their major professional role. In no such instances was it demonstrated that the incorporation of mental health principles in the delivery of services was enhanced.

B. Conclusions and Achievements

1. The Aberdeen Area has a long and complex history. Starting in the middle 60's with planning for the Pine Ridge Community Mental Health Program as one of three pioneering national models for American Indian mental health programs it has expanded until by the end of fiscal 1974 it has established some form of staffing and program in almost every one of its major Service Units.

2. This has been supplemented by contracts with local professional personnel and agencies for services ranging from specialized evaluation of patients to staff development and training. The contract method had been used outside of Pine Ridge, for providing services beyond the capability of the Social Services and General Medical Staff until funding became available for staffing Service Units. Because the standard provisions of the Aberdeen contracts are a well stated description of the philosophy of mental health program development and delivery, it is worth quoting them here. These statements move beyond "boilerplate" and should be thoughtfully considered and carefully monitored, when similar contracts are utilized.

> Community care - Keeping patients as close as possible to their primary social systems is viewed as a desirable goal of these services. The program should intervene in those aspects of community life which effect mental illnesses and health without assuming the major responsibility for social reform.

3. Because of its broad basic commitment to the flexible delivery of services, the Aberdeen Area has achieved excellent integration of IHS mental Health and Social Services with state, local and other federal programs in many of its Service Units. These local networks of service delivery and utilization are typical of the goals of many Areas, and show remarkable achievement in interagency participation.

4. In some instances a similar integration of programs at the tribal level has also been initiated, usually involving CAP, Tribal alcoholism programs and Tribal Courts.

5. A real contribution has been made to development of national standards in both the matter of a career ladder for paraprofessional personnel and in the beginnings of setting operational descriptions of levels

of problems and goals of treatment appropriate to each of five major areas of Mental Health concern.

6. The establishment of an integrated Mental Health and Social Services Area-wide program is a first for the IHS. In the Aberdeen Area it has a foundation of deep initial commitment marked by the project at Flandreau School and the early use of contracts for specialized mental health services, as well as the preplanning stages of the Pine Ridge program. There are still problems to be resolved as noted above, but this achievement as an administrative accomplishment is a milestone in the history of IHS Mental Health Programs.

APPENDICES

A. Suicide Statistics 1969-1973

B. Proposal for Mental Health Worker Position Series

C. Goals of Treatment and Levels of Intervention

APPENDIX A

NUMBER OF DISCHARGES AND HOSPITAL DAYS FOR SUICIDE ATTEMPTS BY AGE GROUP - PHS INDIAN HOSPITALS - FY-1973

ABERDEEN AREA TOTAL

DIRECT PROGRAM

ICDA Code	Suicide Attempts	Total Disch. No.	Total Disch. ALOS*	Age Distribution-Years 10-14	15-24	25-44	45-64	Unk.
	TOTAL ALL TYPES	244	-	8	129	80	20	7
E950	Self-inflicted poisoning by solid or liquid substances	206	2.0	8	103	70	20	5
.0	Barbituric acid and derivatives	9	1.7	-	4	5	-	-
.1	Salicylates and congeners	36	2.0	3	20	10	2	1
.2	Psychotherapeutic agents	26	2.2	-	16	7	3	-
.3	Other and unspecified drugs	129	2.0	5	60	45	15	4
.9	Other & unspec. solid & liq. sub.	6	1.8	-	3	3	-	-
E953	Self-inflicted injury by hanging, strangulation & suffocation	1	1.0	-	-	-	-	1
E955	Self-inflicted injury by firearms & explosives	2	1.5	-	1	1	-	-
E956	Self-inflicted injury by cutting & piercing instr.	34	2.4	-	24	9	-	1
E958	Self-inflicted injury by other & unspec. means	1	2.0	-	1	-	-	-
	Belcourt PHS Indian Hospital	17	-	-	6	8	2	1
	Cass Lake PHS Indian Hospital	15	-	1	6	7	1	-
	Eagle Butte PHS Indian Hospital	28	-	2	11	12	1	2
	Fort Yates PHS Indian Hospital	35	-	1	20	10	4	-
	Pine Ridge PHS Indian Hospital	35	-	2	17	11	4	1
	Redlake PHS Indian Hospital	22	-	1	13	3	5	-
	Rapid City (GM) PHS Indian Hospital	28	-	-	15	12	1	-
	Rosebud PHS Indian Hospital	36	-	1	24	9	1	1
	Sisseton PHS Indian Hospital	13	-	-	8	3	-	2
	Wagner PHS Indian Hospital	13	-	-	8	4	1	-
	Winnebago PHS Indian Hospital	2	-	-	1	1	-	-

Suicide Attempt Discharges (244) as Percent of Total Discharges (15,688) is 1.6%.

* Average Length of Stay

SOURCE: Computer Inpatient Report 2.B

Table 2

NUMBER OF DISCHARGES AND HOSPITAL DAYS FOR SUICIDE ATTEMPTS BY AGE GROUP - CONTRACT HOSPITAL - FISCAL YEAR 1973

ABERDEEN AREA TOTAL

CHS PROGRAM

ICDA Code	Suicide Attempt	Total Disch. No.	Total Disch. ALOS*	Total Cost	Age Distribution-Years 10-14	Age Distribution-Years 15-24	Age Distribution-Years 25-44
	TOTAL ALL TYPES	13	-	$7,672.08	2	7	4
E950	Self-inflicted poisoning by solid or liquid substances	8	5.0	6,636.28	2	4	2
.1	Salicylates and congeners	2	1.5	245.10	1	-	1
.2	Psychotherapeutic Agents	2	3.5	339.45	-	1	1
.3	Other and unspecified drugs	4	7.5	6,051.73	1	3	-
E956	Self-inflicted injury by cutting & piercing instr.	5	3.2	1,035.80	-	3	2
	Cheyenne River Service Unit	1	4.0	168.00	-	-	1
	Fort Berthold Service Unit	1	1.0	77.60	1	-	-
	Fort Totten Service Unit	1	2.0	167.50	-	-	1
	Lac Courte Oreilles Service Unit	1	1.0	94.40	-	1	-
	Lac du Flambeau Service Unit	2	1.5	196.75	-	2	-
	Pierre Service Unit	3	4.0	626.40	-	1	2
	Pine Ridge Service Unit	1	4.0	416.10	-	1	-
	Sisseton-Wahpeton Service Unit	1	25.0	5,695.64	-	1	-
	White Earth Service Unit	1	2.0	116.00	-	1	-
	Wahpeton School Health Center	1	2.0	113.69	1	-	-

* Average Length of Stay

SOURCE: Computer CHS Report 3.H

Table 3

SUICIDE ATTEMPTS
FISCAL YEAR 1973

					APC DIRECT PROGRAM
	Suicide Attempts			Total 1st Visits For Injury	Suicide Attempts Per 1,000 Injury 1st Visits
		Alcohol Related			
Service Unit	Number	No.	Percent		
AREA TOTAL	298	113	37.9%	22,094*	13.5
Cheyenne River	2	1	50.0	1,271	1.6
Greater Leech Lake	23	12	52.2	1,288	17.9
Omaha-Winnebago	13	5	38.5	1,557	8.3
Pine Ridge	33	18	54.5	3,107	10.6
Rapid City	24	4	16.7	1,592	15.1
Redlake	47	12	25.5	2,151	21.9
Rosebud	41	5	12.2	2,691	15.2
Sisseton-Wahpeton	13	5	38.5	854	15.2
Standing Rock	48	26	54.2	1,742	27.6
Turtle Mountain	14	5	35.7	2,162	6.5
Yankton	22	10	45.5	750	29.3
Fort Berthold	14	10	71.4	987	14.2
Fort Totten	3	-	-	552	5.4
Pierre	1	-	-	129	7.8
White Earth	-	-	-	498	-
Flandreau SHC	-	-	-	336	-
Pierre SHC	-	-	-	192	-
Wahpeton SHC	-	-	-	235	-

* Excludes counts for data from 486 visits at Eagle Butte which were not reported on "APC" forms.

SOURCE: Computer "APC" Report 1.F

Table 4

SUICIDE ATTEMPTS
FISCAL YEAR 1973

CHS PROGRAM

Service Unit	Total 1st Visit For Injury	Suicide Attempts Number	Suicide Attempts Per 1,000 Injury 1st Visits
AREA TOTAL	4,305	21	4.9
Cheyenne River	37	1	27.0
Greater Leech Lake	-	-	-
Omaha-Winnebago	9	-	-
Pine Ridge	40	-	-
Rapid City	48	-	-
Redlake	48	-	-
Rosebud	18	-	-
Sisseton-Wahpeton	34	2	58.8
Standing Rock	36	-	-
Turtle Mountain	91	-	-
Yankton	61	1	16.4
Fort Berthold	295	2	6.8
Fort Totten	235	-	-
Pierre	1,171	5	4.3
White Earth	477	-	-
Flandreau SHC	48	-	-
Flandreau	14	-	-
Pierre SHC	-	-	-
Wahpeton SHC	58	-	-
Aberdeen AO	18	-	-
Bemidji	-	-	-
Fond du Lac	58	-	-
Grand Portage	40	-	-
Lac Courte Oreilles	554	3	5.4
Lac du Flambeau	489	6	12.3
Mille Lacs	170	-	-
Minnesota Sioux	85	1	11.8
Nett Lake	65	-	-
Sac & Fox	64	-	-
Western Michigan	20	-	-
Eastern Michigan	22	-	-

SOURCE: Computer CHS Report 3-D

Table 5

SUICIDE ATTEMPTS
FY-69, FY-71, FY-72 & FY-73

Service Unit	Number of Suicide Attempts			Attempt Rate Per 100,000 Population			Percent Change 73/71	Fiscal Year 1969 Number of Suicide Attempts	Fiscal Year 1969 Attempt Rate Per 100,000 Population
	FY-73	FY-72	FY-71	FY-73	FY-72	FY-71			
AREA TOTAL	298	304	328*	554.1	573.6	628.1	- 11.8%	180*	365.9
Cheyenne River	2	2	2	50.5	51.3	52.2	- 3.3%	5	142.9
Greater Leech Lake	23	14	10	981.6	598.3	427.9	+129.4%	16	640.0
Omaha-Winnebago	13	7	6	598.3	325.1	281.3	+112.7%	4	200.0
Pine Ridge	33	54	121	325.3	544.0	1246.7	- 73.9%	41	488.1
Rapid City	24	25	39	925.6	987.4	1578.3	- 41.4%	9	333.3
Redlake	47	41	31	1549.6	1354.5	1026.2	+ 51.0%	25	862.1
Rosebud	41	59	48	607.4	899.7	754.0	- 19.4%	29	568.6
Sisseton-Wahpeton	13	14	10	561.6	607.4	435.7	+ 28.9%	2	83.3
Standing Rock	48	34	35	1239.3	566.1	916.0	+ 35.3%	16	376.5
Turtle Mountain	14	22	10	228.4	366.3	170.0	+ 34.4%	14	274.5
Yankton	22	16	11	1856.5	1333.3	895.0	+107.4%	2	100.0
Fort Berthold	14	9	-	601.9	387.1	-	-	7	304.3
Fort Totten	3	2	-	165.4	112.1	-	-	0	-
Pierre	1	2	-	39.4	79.8	-	-	9	418.6
White Earth	-	3	4	-	116.0	155.5	-	0	-

* Includes 1 at Flandreau School Health Center.

Exercise extreme caution in interpreting above data because counts excluded data from about fifty-six hundred visits in FY-72 and five hundred visits in FY-73 which were not reported on "APC" forms, plus a diagnosis (clinical impression) omission error rate for the Area occurred of 1.7 per 100 documents in FY-72 and 6.1 per 100 documents in FY-73 lead by Pine Ridge with 22.0%, Turtle Mountain with 13.3%, and Cheyenne River with 4.3%.

TABLE 1

NUMBER OF DISCHARGES AND HOSPITAL DAYS FOR SUICIDE ATTEMPTS BY AGE GROUP - PHS INDIAN HOSPITALS - FY-1971

ABERDEEN AREA TOTAL

DIRECT PROGRAM

ICDA Code	Suicide Attempts	Total Disch. No.	Total Disch. ALOS*	Age Distribution-Years 10-14	15-24	25-44	45-64	65+
	TOTAL ALL TYPES	207	-	14	121	64	7	1
E950	Self-inflicted poisoning by solid or liquid substances	173	2.4	14	98	54	7	-
.0	Barbituric acid and derivatives	16	3.4	2	9	5	-	-
.1	Salicylates and congeners	44	1.8	3	32	8	1	-
.2	Psychotherapeutic agents	28	1.8	1	8	16	3	-
.3	Other and unspecified drugs	79	2.8	8	46	22	3	-
.9	Other & unspec. solid & liq. sub.	6	2.8	-	3	3	-	-
E952	Self-inflicted poisoning by other gases	2	2.0	-	2	-	-	-
E953	Self-inflicted injury by hanging, strangulation & suffocation	2	3.5	-	1	-	-	1
E954	Self-inflicted injury by submersion	1	1.0	-	-	1	-	-
E955	Self-inflicted injury by firearms & explosives	1	6.0	-	1	-	-	-
E956	Self-inflicted injury by cutting & piercing instr.	27	1.8	-	18	9	-	-
E958	Self-inflicted injury by other & unspec. means	1	3.0	-	1	-	-	-

Belcourt PHS Indian Hospital	8	-	-	3	4	1	-
Cass Lake PHS Indian Hospital	6	-	-	3	3	-	-
Eagle Butte PHS Indian Hospital	28	-	4	19	5	-	-
Fort Yates PHS Indian Hospital	6	-	-	1	3	2	-
Pine Ridge PHS Indian Hospital	52	-	5	34	11	2	-
Redlake PHS Indian Hospital	26	-	1	17	6	1	1
Rapid City (GM) PHS Indian Hospital	32	-	1	12	18	1	-
Rosebud PHS Indian Hospital	30	-	3	20	7	-	-
Sisseton PHS Indian Hospital	7	-	-	6	1	-	-
Wagner PHS Indian Hospital	7	-	-	3	4	-	-
Winnebago PHS Indian Hospital	5	-	-	3	2	-	-

Suicide Attempt Discharges (207) as Percent of Total Discharges (13,134) is 1.6%

* Average Length of Stay

SOURCE: Computer Inpatient Report 2.B

TABLE 2

NUMBER OF DISCHARGES AND HOSPITAL DAYS FOR SUICIDE ATTEMPTS BY AGE GROUP - CONTRACT HOSPITAL - FISCAL YEAR 1971

CHS PROGRAM

ICDA Code	Suicide Attempt	Total Disch.		Total Cost	Age Distribution-Years		
		No.	ALOS*		15-24	25-44	45-64
	AREA TOTAL	9	-	$4,013.25	3	5	1
E950	Self-inflicted poisoning by solid or liquid substances	7	2.0	894.05	3	3	1
.0	Barbituric acid and derivatives	2	4.0	441.10	1	1	-
.2	Psychotherapeutic agents	1	1.0	28.10	-	1	-
.3	Other and unspecified drugs	4	1.3	424.85	2	1	1
E955	Self-inflicted injury by firearms & explosives	1	78.0	2,680.00	-	1	-
E956	Self-inflicted injury by cutting & piercing instr.	1	6.0	439.20	-	1	-
	Fort Berthold Service Unit	2	1.5	$ 120.00	2	-	-
	Pierre Service Unit	3	3.0	703.40	-	2	1
	Pine Ridge Service Unit	1	1.0	120.65	1	-	-
	Omaha-Winnebago Service Unit	1	78.0	2,680.00	-	1	-
	White Earth Service Unit	2	3.5	389.20	-	2	-

* Average Length of Stay

SOURCE: Computer CHS Report 3.H

TABLE 3

SUICIDE ATTEMPTS
FISCAL YEAR 1971

APC DIRECT PROGRAM

Service Unit	Suicide Attempts Number	Alcohol Related No.	Alcohol Related Percent	Total 1st Visits For Injury	Suicide Attempts Per 1,000 Injury 1st Visits
AREA TOTAL	328	112	34.1%	20,588	15.9
Cheyenne River	2	2	100.0	1,074	1.9
Greater Leech Lake	10	3	30.0	1,093	9.1
Omaha-Winnebago	6	3	50.0	1,396	4.3
Pine Ridge	121	25	20.7	3,474	34.8
Rapid City	39	17	43.6	1,685	23.1
Redlake	31	11	35.5	1,683	18.4
Rosebud	48	18	37.5	2,229	21.5
Sisseton-Wahpeton	10	5	50.0	722	13.9
Standing Rock	35	23	65.7	1,695	20.6
Turtle Mountain	10	1	10.0	2,165	4.6
Yankton	11	3	27.3	772	14.2
Fort Berthold	-	-	-	303	-
Fort Totten	-	-	-	575	-
Pierre	-	-	-	274	-
White Earth	4	1	25.0	604	6.6
Flandreau SHC	1	-	-	463	2.2
Pierre SHC	-	-	-	184	-
Wahpeton SHC	-	-	-	197	-

SOURCE: Computer "APC" Report 1.F

TABLE 4

SUICIDE ATTEMPTS
FISCAL YEAR 1971

			CHS PROGRAM
Service Unit	Total 1st Visit For Injury	Suicide Attempts Number	Suicide Attempts Per 1,000 Injury 1st Visits
AREA TOTAL	3,205	20	6.2
Cheyenne River	33	-	-
Greater Leech Lake	0	-	-
Omaha-Winnebago	55	-	-
Pine Ridge	64	-	-
Rapid City	65	1	15.4
Redlake	30	-	-
Rosebud	100	1	10.0
Sisseton-Wahpeton	37	-	-
Standing Rock	34	-	-
Turtle Mountain	38	-	-
Yankton	21	1	47.6
Fort Berthold	739	2	2.7
Fort Totten	137	-	-
Pierre	742	11	14.8
White Earth	391	-	-
Flandreau SHC	32	-	-
Flandreau	5	-	-
Wahpeton SHC	77	-	-
Bemidji	5	-	-
Fond du Lac	23	1	43.5
Grand Portage	1	-	-
Lac Courte Oreilles	276	-	-
Lac du Flambeau	190	2	10.5
Mille Lacs	17	-	-
Minnesota Sioux	7	-	-
Nett Lake	21	-	-
Sac & Fox	57	1	17.5
Western Michigan	8	-	-

SOURCE: Computer CHS Report 3.D

SUICIDE ATTEMPTS
FY-69 AND FY-71

	Fiscal Year 1971		Fiscal Year 1969	
Service Unit	Number of Suicide Attempts	Attempt Rate Per 100,000 Population	Number of Suicide Attempts	Attempt Rate Per 100,000 Population
AREA TOTAL	328*	628.1	180*	365.9**
Cheyenne River	2	52.2	5	142.9
Greater Leech Lake	10	427.9	16	640.0
Omaha-Winnebago	6	281.3	4	200.0
Pine Ridge	121	1246.7	41	488.1
Rapid City	39	1578.3	9	333.3
Redlake	31	1026.2	25	862.1
Rosebud	48	754.0	29	568.6
Sisseton-Wahpeton	10	435.7	2	83.3
Standing Rock	35	916.0	16	376.5
Turtle Mountain	10	170.0	14	274.5
Yankton	11	895.0	2	100.0
Fort Berthold	-	-	7	304.3
Fort Totten	-	-	0	-
Pierre	-	-	9	418.6
White Earth	4	155.5	0	-

* Includes 1 at Flandreau School Health Center.

SOURCE: FY-71 - APC Form - Computer "APC" Report 1.F
FY-69 - Special Survey By Occurrence Report AAO-156 (4/68)

TABLE 6

SUICIDE DEATHS AND DEATH RATES

Indian Aberdeen Area, Indian 24-Federal Reservation States, and U.S. All Races
Calendar Year 1968
Rates Per 100,000 Population

	Area Total	State Distribution a/						
		Iowa	Mich.	Minn.	Nebr.	N.Dak.	S.Dak.	Wisc.
A. Number of Suicide Deaths	24	-	2	2	1	3	13	3
From poisoning by solid or liquid sub.	7	-	2	1	1	2	1	-
From poisoning by gases	1	-	-	-	-	-	-	1
By hanging, strangulation & suffocation	9	-	-	-	-	1	6	2
By firearm and explosive	6	-	-	1	-	-	5	-
By all other means	1	-	-	-	-	-	1	-
B. Suicide Death Rates Per 100,000 Population								
Indian Aberdeen Area Total	25.6							
Indian By State in Area		-	17.4	11.8	15.6	23.3	45.8	19.4

a/ For total Indian within each State.

SOURCE: N.C.H.S. Special Tabulations

TABLE 7

SERVICE UNIT SUICIDE ATTEMPT RATES
per 100,000

STATION:	FY '69 RATES:	FY '71 RATES:	CHANGE FACTORS:	Mental Health or Social Service Staff in FY '69:
Eagle Butte	142.9	(52.2)	-	1
Cass Lake	640.0	427.9	.68	1
Red Lake	862.1	1026.2	1.19	
Turtle Mountain	274.5	170.0	.62	1
Omaha-Winnebago	200.0	281.3	1.40	1
Rosebud	586.6	754.0	1.33	1
Sisseton	83.3	435.7	5.24	0
Fort Yates	376.5	916.0	2.44	0
Yankton	100.0	895.0	8.95	0
Pine Ridge	488.1	1246.7	2.53	4
Rapid City	333.3	1578.3	4.74	3

Table 1

NUMBER OF DISCHARGES AND HOSPITAL DAYS FOR SUICIDE ATTEMPTS BY AGE GROUP - PHS INDIAN HOSPITALS - FY-1972

ABERDEEN AREA TOTAL — DIRECT PROGRAM

		Total Disch.		Age Distribution-Years				
ICDA Code	Suicide Attempts	No.	ALOS*	10-14	15-24	25-44	45-64	65+
	TOTAL ALL TYPES	226	-	19	111	78	14	2
E950	Self-inflicted poisoning by solid or liquid substances	206	2.2	19	97	73	13	2
.0	Barbituric acid and derivatives	14	3.4	-	6	7	1	-
.1	Salicylates and congeners	48	1.4	4	26	17	-	1
.2	Psychotherapeutic agents	26**	2.1	1	9	12	3	-
.3	Other and unspecified drugs	110**	2.5	14	52	34	9	-
.9	Other & unspec. solid & liq. sub.	8	2.0	-	4	3	-	1
E953	Self-inflicted injury by hanging strangulation & suffocation	3	2.7	-	2	1	-	-
E955	Self-inflicted injury by firearms & explosives	1	3.0	-	1	-	-	-
E956	Self-inflicted injury by cutting & piercing instr.	12	1.8	-	8	4	-	-
E958	Self-inflicted injury by other & unspec. means	4	1.0	-	3	-	1	-
	Belcourt PHS Indian Hospital	17	-	1	10	4	2	-
	Cass Lake PHS Indian Hospital	11	-	1	4	5	1	-
	Eagle Butte PHS Indian Hospital	23	-	2	11	10	-	-
	Fort Yates PHS Indian Hospital	28**	-	1	13	12	-	1
	Pine Ridge PHS Indian Hospital	32	-	3	14	14	1	-
	Redlake PHS Indian Hospital	36	-	4	16	8	7	1
	Rapid City (GM) PHS Indian Hospital	18	-	-	11	7	-	-
	Rosebud PHS Indian Hospital	45**	-	7	24	12	1	-
	Sisseton PHS Indian Hospital	5	-	-	2	1	2	-
	Wagner PHS Indian Hospital	8	-	-	4	4	-	-
	Winnebago PHS Indian Hospital	3	-	-	2	1	-	-

Suicide Attempt Discharges (226) as Percent of Total Discharges (14,382) is 1.6%

* Average Length of Stay
** Includes 1 with age unknown

SOURCE: Computer Inpatient Report 2.B

Table 2

NUMBER OF DISCHARGES AND HOSPITAL DAYS FOR SUICIDE ATTEMPTS BY AGE GROUP - CONTRACT HOSPITAL - FISCAL YEAR 1972

		ABERDEEN AREA TOTAL			CHS PROGRAM		
					Age Distribution-Years		
		Total Disch.					
ICDA Code	Suicide Attempt	No.	ALOS*	Total Cost	10-14	15-24	25-44
	TOTAL ALL TYPES	13	-	$4,225.50	1	3	9
E950	Self-inflicted poisoning by solid or liquid substances	9	2.9	2,138.90	1	3	5
.2	Psychotherapeutic agents	3	1.7	256.20	1	-	2
.3	Other and unspecified drugs	5	4.0	1,841.95	-	3	2
.9	Other & unspec. solid & liquid substances	1	1.0	40.75	-	-	1
E955	Self-inflicted injury by firearms & explosives	1	31.0	1,427.10	-	-	1
E956	Self-inflicted injury by cutting & piercing instr.	3	4.0	659.50	-	-	3
	Fort Berthold Service Unit	2	4.0	$ 391.65	-	-	2
	Lac Courte Oreilles Service Unit	1	7.0	413.65	-	-	1
	Lac du Flambeau Service Unit	1	31.0	1,427.10	-	-	1
	Pierre Service Unit	3	2.0	323.25	1	1	1
	Pine Ridge Service Unit	3	4.7	1,454.85	-	2	1
	White Earth Service Unit	1	1.0	101.00	-	-	1
	Yankton Service Unit	2	1.0	114.00	-	-	2

* Average Length of Stay

SOURCE: Computer CHS Report 3.H

Table 3

SUICIDE ATTEMPTS
FISCAL YEAR 1972

APC DIRECT PROGRAM

Service Unit	Suicide Attempts			Total 1st Visits For Injury	Suicide Attempts Per 1,000 Injury 1st Visits
		Alcohol Related			
	Number	No.	Percent		
AREA TOTAL	304	114	37.5%	21,765*	14.0
Cheyenne River	2	-	-	661	3.0
Greater Leech Lake	14	4	28.6	1,265	11.1
Omaha-Winnebago	7	2	28.6	1,376	5.1
Pine Ridge	54	17	31.5	3,478	15.5
Rapid City	25	13	52.0	1,788	14.0
Redlake	41	16	39.0	2,039	20.1
Rosebud	59	17	28.8	2,404	24.5
Sisseton-Wahpeton	14	10	71.4	858	16.3
Standing Rock	34	17	50.0	1,725	19.7
Turtle Mountain	22	3	13.6	2,578	8.5
Yankton	16	7	43.8	757	21.1
Fort Berthold	9	5	55.6	658	13.7
Fort Totten	2	-	-	439	4.6
Pierre	2	1	50.0	282	7.1
White Earth	3	2	33.7	599	5.0
Flandreau SHC	-	-	-	464	-
Pierre SHC	-	-	-	171	-
Wahpeton SHC	-	-	-	223	-

* Excludes 4,668 visits at Eagle Butte and 885 visits at Rosebud which were not reported on "APC" forms.

SOURCE: Computer "APC" Report 1.F

Table 4

SUICIDE ATTEMPTS
FISCAL YEAR 1972

CHS PROGRAM

Service Unit	Total 1st Visit For Injury	Suicide Attempts Number	Suicide Attempts Per 1,000 Injury 1st Visits
AREA TOTAL	3,665	24	6.5
Cheyenne River	42	-	-
Greater Leech Lake	1	-	-
Omaha-Winnebago	34	-	-
Pine Ridge	67	3	44.8
Rapid City	63	-	-
Redlake	75	2	26.7
Rosebud	85	2	23.5
Sisseton-Wahpeton	30	-	-
Standing Rock	46	-	-
Turtle Mountain	156	-	-
Yankton	68	3	44.1
Fort Berthold	466	6	12.9
Fort Totten	210	1	4.8
Pierre	900	3	3.3
White Earth	432	-	-
Flandreau SHC	41	1	24.4
Flandreau	6	-	-
Pierre SHC	27	-	-
Wahpeton SHC	62	-	-
Aberdeen AO	3	-	-
Bemidji	3	-	-
Fond du Lac	48	-	-
Grand Portage	12	-	-
Lac Courte Oreilles	322	3	9.3
Lac du Flambeau	332	-	-
Mille Lacs	24	-	-
Minnesota Sioux	18	-	-
Nett Lake	10	-	-
Sac & Fox	54	-	-
Western Michigan	11	-	-
Eastern Michigan	17	-	-

SOURCE: Computer CHS Report 3.D

SUICIDE ATTEMPTS
FY-69, FY-71 AND FY-72

Service Unit	Number of Suicide Attempts		Attempt Rate Per 100,000 Population		Fiscal Year 1969	
	FY-72	FY-71	FY-72	FY-71	Number of Suicide Attempts	Attempt Rate Per 100,000 Population
AREA TOTAL	304	328*	573.6	628.1	180*	365.9
Cheyenne River	2	2	51.3	52.2	5	142.9
Greater Leech Lake	14	10	598.3	427.9	16	640.0
Omaha-Winnebago	7	6	325.1	281.3	4	200.0
Pine Ridge	54	121	544.0	1246.7	41	488.1
Rapid City	25	39	987.4	1578.3	9	333.3
Redlake	41	31	1354.5	1026.2	25	862.1
Rosebud	59	48	899.7	754.0	29	568.6
Sisseton-Wahpeton	14	10	607.4	435.7	2	83.3
Standing Rock	34	35	566.1	916.0	16	376.5
Turtle Mountain	22	10	366.3	170.0	14	274.5
Yankton	16	11	1333.3	895.0	2	100,0
Fort Berthold	9	-	387.1	-	7	304.3
Fort Totten	2	-	112.1	-	0	-
Pierre	2	-	79.8	-	9	418.6
White Earth	3	4	116.0	155.5	0	-

* Includes 1 at Flandreau School Health Center

SOURCE: FY-71 and FY-72 - APC Form - Computer "APC" Report 1.F
FY-69 - Special Survey By Occurrence Report AAO-156 (4/68)

Table 6

SUICIDE DEATHS AND DEATH RATES

Indian Aberdeen Area, Indian 24-Federal Reservation States, and U.S. All Races
Calendar Year 1971
Rates Per 100,000 Population

	Area	State Distribution a/						
	Total	Iowa	Mich.	Minn.	Nebr.	N.Dak.	S.Dak.	Wisc.
A. Number of Suicide Deaths	29	-	1	6	1	5	15	1
From poisoning by solid or liquid sub.	10	-	-	1	-	2	7	-
From poisoning by gases	-	-	-	-	-	-	-	-
By hanging, strangulation & suffocation	5	-	-	-	-	-	5	-
By firearm and explosive	11	-	1	3	1	3	2	1
By all other means	3	-	-	2	-	-	1	-
B. Suicide Death Rates Per 100,000 Population								
Indian Aberdeen Area Total	24.5							
Indian By State in Area		-	5.7	25.1	14.9	34.2	45.4	5.2
Indian 24-Federal Reservation States	18.7							
U.S. All Races	11.1							
C. Suicide Deaths as Percent of Total Deaths								
Indian Aberdeen Area Total	2.6%							
Indian 24-Federal Reservation States	2.4%							
D. Ratio Indian Death Rate to U. S. All Races Rates								
Aberdeen Area	2.2							
24-Federal Reservation States	1.7							

a/ For total Indian within each State.

SOURCE: N.C.H.S. Special Tabulations

PROPOSAL FOR MENTAL HEALTH WORKER POSITION SERIES

At the present time this proposal contains only the basic information developed by a committee in the Aberdeen Area Indian Health Service. It is assumed that it will be expanded and refined many times before it is submitted to the Civil Service Commission. In the development of this series we have assumed that the entry grade for the mental health worker would be GS-5 and that the journeyman grade would be a GS-9. It has been generally felt that this should be a double graded series and thus we have three levels, GS-5, GS-7 and GS-9. We suggest that grades GS-11 and higher will involve duties that would not necessarily be a part of this series, such as supervision and administrative functions.

This series is designed to be used for paraprofessionals in mental health, social service and related behavioral sciences. It is also specifically designed to be a guideline for those positions which involve working with people. As of the present it is not geared for research or teaching roles (existing position series, such as psychology technician adequately fill this need). Also a specific effort has been made to avoid slanting the roles toward a particular discipline, such as psychology or social work.

For each grade there is a general description of the degree of independent functioning at that level and there is also a description of the type of functions performed within the following categories:

1. Individual therapy
2. Group and family therapy
3. Advisor on cross-cultural factors
4. Utilization of existing resources
5. Working in community groups
6. Working with community leaders
7. Consultation

GRADE GS-5:

When the mental health worker first enters at this grade he will assume minimal responsibility and the supervisor will assign tasks, provide direction and review all work. As the mental health worker acquires experience and receives inservice training he will assume more independent functioning in that a supervisor assigns most tasks, provides general direction and makes regular frequent reviews of performance.

1. Individual therapy. The mental health worker will begin by developing a relationship and using natural unstructured responsiveness much as a friend or relative would do. With experience and training the worker will assist the patient in objectively reviewing alternative ways to approach problems to enable the patient to make better decisions.

2. Group and family therapy. At first the mental health worker will lead a discussion group to keep the group on the designated topic or common problem. Later on he will conduct groups focused on external problems in which the leader facilitates arriving at a solution.

3. Advisor on cross-cultural factors. At first the mental health worker will provide cultural information to people of similar background and with training and experience will interpret cultural information to people of different backgrounds.

4. Utilization of existing resources. At this level the worker will utilize familiar and readily available resources in providing patient care.

5. Working in community groups. With minimal training and experience the worker may be expected to represent his agency at community group meetings. With further experience he will be expected to bring specific information to community group meetings.

6. Working with community leaders. The worker will provide information and work cooperatively with community leaders.

7. Consultation. The worker is not expected to provide formal consultation at this grade.

GRADE GS-7:

At this level the mental health worker will assume a much greater degree of independent functioning. The supervisor assigns areas of responsibility, provides overall direction and periodically reviews performance.

1. Individual therapy. The mental health worker will perform supportive therapy working in a relationship to bring out the patient's psychological strengths so he can cope with immediate problems. At this level the worker must assume full responsibility for knowing when to refer cases. With experience and training at this level the worker will also assist a patient in using a crisis situation to become psychologically stronger.

2. Group and family therapy. The worker may perform family therapy focused on a particular problem situation.

3. Advisor on cross-cultural factors. At this level the worker will interpret cultural factors which have an impact on program planning and operation.

4. Utilization of existing resources. At this level the worker will also be able to search out resources that are not readily available to fit a patient's needs and with experience will improve and coordinate resources that can be utilized in patient care.

5. Working in community groups. At this level the worker will also be expected to give creative input to a community group to solve a specific task.

At the GS-7 level there are no additional functions in categories 6 and 7.

GRADE GS-9:

At this level the mental health worker assumes considerable independence in that the supervisor assigns general areas of responsibility, provides direction at the request of the worker and makes occasional reviews of performance.

1. Individual therapy. The type of therapy performed will not be substantially different from the GS-7 level except that the worker would be expected to handle more difficult cases.

2. Group and family therapy. At this level the worker may also be expected to conduct developmental and awareness groups (sensitivity, t-group, encounter, etc.) composed of presumably "normal" people who are not designated as patients.

3. Adviser on cross-cultural factors. There are no additional roles in this category.

4. Utilization of existing resources. The mental health worker will also be expected to utilize and coordinate resources in the planning and development of programs.

5. Working in community groups. At this level the worker may also be expected to lead a community group and affect the process of that group so that they deal with problems more effectively.

6. Working with community leaders. This may also involve facilitating the leader's solving a specific problem.

7. Consultation - Inducing a change in the functioning of the consultee in his own area of expertise. At first, the mental health worker may provide consultation with one person in the context of a particular case or problem. With experience he may provide consultation involving a group of people but remaining within the context of a particular case or problem.

GRADES GS-11 AND ABOVE:

As mentioned previously it is assumed that advancement to these grades will be primarily related to the amount of supervisory and administrative functions performed. At this level the worker is fully responsible for functioning within areas of assignment and supervision is largely administrative. The worker seeks technical guidance on his own initiative.

At grades GS-11 and above the following functions may also be performed depending on the requirements of the specific job situation.

1. Individual therapy. This may include therapy to facilitate a major change in problem behavior or thinking. With considerable training and experience the worker may conduct therapy to facilitate a major character or personality change.

2. Group and family therapy. With appropriate experience and training the worker may conduct family therapy to affect a change in the family structure and functioning and may also conduct group therapy to affect major changes in problem behavior and thinking of the members through group process.

7. Consultation. The worker may provide consultation with one person in the context of a program or organization and also may provide consultation with more than one person in the context of a program or organization.

QUALIFICATIONS FOR THE MENTAL HEALTH WORKER POSITION SERIES:

The following material was developed at one committee meeting and considerable revision and additional work will be required.

FOR THE GS-5 GRADE:

A. The person must have the following:

1. Interest in other people
2. Personal warmth
3. Respect for others
4. Believing that people have the capacity to change
5. Understanding the necessity of confidentiality
6. Capacity to learn
7. Capacity to reason with continuums - avoiding polarized concepts
8. Ability to avoid applying one's personal standards to other people
9. Ability to be persistent when appropriate
10. Knowing that trust is essential in a relationship
11. Knowing that no two people are alike
12. Knowledge that a relationship requires acceptance

B. The person must have a "minimal" degree of the following items. It is assumed these will be further developed on the job:

13. Self-confidence
14. Reading and writing skills
15. Listening ability
16. Analytic thinking; ability to use a logical thought process
17. Ability to suspend decision-making when appropriate
18. The ability to remember the content and process of an interview
19. Ability to make a decision when necessary
20. Ability to set limits on personal emotional involvement
21. An awareness of one's own limitations
22. Self-awareness; understanding one's own personality
23. Ability to assess one's own relative position in a group setting
24. Ability to develop interpersonal relationships in a variety of styles

25. Capacity to understand the basic concepts of general systems theory
26. Knowing that development of a relationship follows a time sequence
27. Ability to differentiate and diagnose problem situations
28. Understanding how to treat various types of problems
29. Knowledge of the specific relationships of individuals and groups in a community

FOR THE GS-7 GRADE:

A. The person will need the above items for the GS-5 grade under "A" plus the following:

30. Knowing there are times when no treatment is best
31. Understanding of the concept that a relationship is the vehicle of psychological change
32. Understanding the concept that the client has the major responsibility.

B. The person will need a "medium" or "moderate" degree of the items for the GS-5 grade under "B" above plus the following. All of these will be further developed on the job:

33. Understanding that the pattern of past experience affects the present situation
34. Knowledge of the phenomenon of transference
35. Knowing that there are stages in life experience
36. A general understanding of group process

FOR THE GS-9 GRADE:

A. The person will need all of the items for the GS-7 grade under "A".

B. The person will need a "relatively high" degree of proficiency in the items for the GS-7 grade under "B".

FOR THE GS-11 GRADE AND ABOVE:

When the job at this level involves supervisory or administrative or other functions the qualifications, of course, would fit those functions. When the duties involved more complex functions within the categories described in this series the qualifications probably will be a refinement of some of those listed for the GS-9 grade.

The Mental Health Worker Position Series Committee includes: Joyce Johnson, Cecelia Lee, Francis Montileaux, Ned Byrnes, Al Folz, Paul Kirkham, Jim Rixner, Bob Riesenberg, Betty Glasow and Don Burnap.

APPENDIX C

PROPOSED GOALS OF TREATMENT 1974

Community Mental Health Program Pine Ridge South Dakota

Karen Dixon, M.S.W.

Jay Mason, M.D.

Francis Montileaux, A.A.H.S.

Psychosis 1

Social Contact	Autism	Self Concept
1. minimal or nonexistent meaningful contacts	1. constantly preoccupied with delusions and hallucinations	1. grandiosity 2. worthlessness
1. able to have contact with at least one meaningful other	1. delusions and or hallucinations	1. unrealistic ideas concerning self and/or enviornment
1. able to have meaningful contacts with a few close people	1. acknowledges hall. or del. with extensive interviewing 2. ideas of reference	1. significant doubts about self
1. most of time able to have contacts in and out of home	1. an isolated autistic experience	1. depression 2. uncomfortable with self
1. significant contacts with many	1. none displayed	1. able to discuss self without anxiety

PSYCHOSIS 2

Activity	Cognition	Intervention
1. hyperactive 2. hypoactive 3. acts on autistic thinking	1. lacks sense of reality 2. unable to think coherently 3. looseness of associations 4. non verbal	1. hospitalization 2. follow at hospital 3. attempt to work with family or alternatives with goal of discharge
1. frequent unproductive encounters with agencies 2. frequent periods of extended isolation	1. server ambivalence 2. rambling 3. frequently doesn't make sense	1. medication 2. twice weekly encounters with client or family or agency
1. periods of abnormal behavior which are self limiting	1. frequent ambivalence 2. doesn't always make sense	1. medication 2. realistic plans 3. supportive therapy 4. encourage interaction with others
1. free floating axiety 2. nervous habits	1. makes sense 2. some ambivalence 3. isolated areas of strange thinking	1. limited medication 2. insight therapy if tolerated 3. supportive therapy
1. functions well	1. speaks and thinks rationally 2. occasional ambivalence	1. close case

DEPRESSION 1

Socail Contacts	Suicial Thoughts	Physical Symptoms
1. no sexual desire 2. isolated from all people 3. loss of significant other	1. attempted suicide without primary manipulative element	1. significant wt. loss 2. headaches/backaches,etc,. 3. physical delusions 4. agitated 5. withdrawn 6. insomnic
1. no sexual desire 2. significant troubles with family members 3. isolated from those other than family	1. acted on suicidal thoughts more than once in last 90 days	1. frequently seen in medical clinic 2. general physical complaints with secondary gain 3. waking early in morning 4. poor appetite
1. reduced sexual desire 2. trouble with those other than family 3. some trouble with family members	1. suicidal impulses 4 or more time in last 60 days	1. 1. loss or increase of appetite 2. lethargy
1. minimal trouble of continuing nature with either family or non-family	1. suicidal impulses 1-4 times in last 60 days	1. difficulty getting to sleep 2. anxious
1. supportive socail milue	1. no suicidal thoughts	1. no problems

DEPRESSION 2

Self Esteem	Activities	Intervention
1. worthless ,hopeless 2.no possibility of change	1. no activities inside or outside of home 2. no personal care 3. crying	1. hospitalize 2. follow at hospital 3. attempt to work with family about discharge goals
1. has tried to deal with feelings of worthlessness and hopelessness but failed	1. few or no outside activities 2. able to function at home with supervision 3. cries frequently	1. short 1-3 day hospitalization and/or 2. medications 3. twice weekly contact 4. encourage graded activity plan 5. clarification of physical problems with family and client
. periodically feels helpless	1. able to function in and outside of home marginally 2. cries periodically	1. weekly visits to home or job or school 2. medication 3. supportive therapy
. assertive and feels confident for periods of time	1. functions in and outside of home well-for periods of time	1. bi-weekly visits 2. crisis orientation 3. frequent re-evaluation of client and flexible goals for individual and family
. consistently confident	1. activities normal	1. hire them!

ALCOHOL ABUSE 1

Family	Job/School	Drinking Pattern
1. family has rejected client	1. chronically unemployed 2. drop out	1. prolonged abuse for 1-2 wks or longer before being seen
1. some contact often not pleasant with family members	1. unemployed 2. drop out	1. prolonged abuse until 1-2 days before being seen
1. in family but server long standing stressed relationships	1. employed but frequent job changes 2. truancy	1. prolonged bouts of drinking separated by periods of sobriety
1. in family with periodic crisis often precipitated by alcohol	1. employed 2. in school poor academic record	1. weekend drinker to excess
1. stable family relations	1. employed 1 place longer than 1 yr 2. no school problems	1. abstinent 2. controlled drinking

Psychological/physical Problems	Arrests	Intervention
1. hallucinations 2. delusions 3. tremors 4. combative 5. physical deterioration	1. multiple past arrests 2. brought from jail 3. violent acts	1. hospitalization/detoxification 2. referral to treatment center 3. planned follow up-family,job,school
1. irritable 2. nervous 3. tremors 4. insomnic 5. physical debilitation	1. past arrests 2. often brought from jail	1.medication 2. referral to community alcohol group 3. family therapy or change residence 4. employment
1. nervous 2. intoxicated 3. poor physical health	1. some minor violations 2. violence/neglect/abuse	1. medication 2. supportive therapy 3. family therapy 4. referral to community group
1. depression 2. fearfull/anxious	1. very rare arrests	1. family therapy 2. Antabuse 3. other medications 4. personal insight therapy
1. possibly some residual physical limitations	1. 1 year without arrests	1. 1 year sobriety

CHILD ABUSE/CHILD NEGLECT 1

Dependency/Independency	Drinking Pattern	Family Stability
1. excessively dependent	1. rarely sober	1. divorce,separation,loss 2. unwed mothers 3. extreme instability
1. able to manage own life marginally when sober	1. rarely sober	1. unwed,divorced 2. dependent mothers living within own mother's household
1. overwhelmed by parental respondsibilities	1. occasional binge drinking	1. unwed,divorced 2. dependent mothers living within own mother's household 3. a man periodically home
1. able to handle all but crisis situations	1. rarely drinks	1. some other significant family member upon whom client depends 2. fairly stable family
1. capable of functioning independently	1. sober	1. members of household are consistent and supportive

Radius of Interpersonal Relations	Arrest Record	Intervention
1. very narrow within and out of family 2. no supportive individuals within enviornment	1. frequently extensive 2. males-history of felonies	1. report abuse to hospital social worker 2. evaluate current psychosocial situation 3. conjoint program with other agencies 4. carry out program
1. welfare agency sole contact 2. troubles with schools 3. highly mobile with few permanent attachments	1. sparodic 2. monthly binge arrest	1. stabalize living arrangements 2. work with school 3. alcohol treatment 4. develope supportive relationship allowing client to be dependent 5. 3 hrs./wk for first 8 wks
1. 2 or more agencies envolved 2. one or two close friends	1. not more than 1 in last 90 days	1. supportive dependent relationship 2. alcohol treatment 3. treat depression-medication 4. coordinate agencies' efforts 5. help to expend radius of relations.
1. greater than 2 close friends 2. activity in some community group	1. none within last year	1. supportive therapy 2. encourage radius of friends be expanded 3. marital therapy 4. crisis intervention
1. extensive radius of interpersonal relations	1. no arrest 1 1/2 years	1. when child becomes 18 records destroyed

SCHOOL PROBLEMS 1

School Behavior	Home Behavior	Maturational Level Psychological/Social/Cognitive
1. consistently truant	1. relationships extremely poor 2. run aways 3. excessively dependent	1. greater than 2 years behind in one or more maturational level
1. frequently truant 2. hyperactivity 3. unable to follow teacher's orders 4. socially isolate	1. hyperactivity 2. socially isolate 3. disruptive	1. 2 years behind in one or more maturational area
1. rarely truant 2. very active 3. sensitive 4. frequently disruptive 5. acedemics borderline	1. very active 2. sensitive 3. disruptive	1. 1-2 years behind in one or more maturational area
1. unhappy 2. 1-2 areas of poor acedemic performance 3. sudden change	1. good(or too good) at home	1. 0-1/2 years behind in one or more maturational areas
1. consistent 2. no learning problems 3. appropriate behavior	1. no pathologic behavior	1. age appropriate

SCHOOL PROBLEMS 2

Family	Medical/Psychological Problems	Intervention
1. unenvolved with child 2. overprotective parents	1. psychotic 2. mentally retarded 3. chronic server illness 4. siezure disorders	1. medical/social evaluation 2. institutionalization 3. work with family for discharge goals
1. unenvolved with child 2. overprotective parents	1. mentally retarded 2. chronic server illness 3. siezure disorders 4. hyperkenetic child 5. frquent clinic visitor	1. thorough medical evaluation and treatment 2. psychological evaluation 3. medication 4. special education 5. work with family and school
1. unstable 2. mobile 3. multiple parents	1. depressed 2. anxious 3. school phobia 4. enuresis	1. psychological evaluation 2. medication 3. group activities 4. stabalize family 5. special education 6. family envolvement with school
1. relatively stable 2. at least 1 parent with whom child is comfortable	1. occasional anxiety	1. crisis intervention 2. school remediation in areas of poor performance 3. work with school counselor 4. medication
1. supportive 2. stable 3. envolved in school	1. none or minor	1. determine level of functioning 1 year after case closed